

VOL. I.

OCTOBER, 1896.

NO. 4.

THE
LARYNGOSCOPE
A MONTHLY JOURNAL
DEVOTED TO DISEASES OF THE
NOSE = THROAT = EAR
FOR GENERAL PRACTITIONERS AND SPECIALISTS.

EDITORS.

FRANK M. RUMBOLD, M.D.

M. A. GOLDSTEIN, M.D.

ASSOCIATE EDITORS.

M. D. LEDERMAN, M.D.
New York.

S. SCOTT BISHOP, M.D.
Chicago.

W. SCHEPPEGRELL, M.D.
New Orleans.

F. B. EATON, M.D.
San Jose, Cal.

FOREIGN EDITORS.

DR. J. DUNDAS GRANT,
England.

DR. VICTOR URBANTSCHITSCH,
Austria.

DR. J. J. KIRK DUNCANSON,
Scotland.

DR. A. HARTMANN,
Germany.

DR. J. K. KIMURA,
Japan.

DR. G. STERLING RYERSON,
Canada.

DR. FREDERICK SEMELEDER,
Mexico.

DR. GOTTLIEB KÜER,
Denmark.

FOR CONTENTS SEE NEXT PAGE.

SUBSCRIPTION, \$2.00 PER ANNUM, IN ADVANCE.

P. O. BOX 787.

ST. LOUIS, MO.

OFFICE OF PUBLICATION, 707 OLIVE STREET.

[Entered at the Post Office at St. Louis, Mo., as Second-Class Matter, in July, 1896.]

CONTENTS.

ORIGINAL COMMUNICATIONS.

Syphilitic Ulcers of the Pharynx. By A. H. Ohmann - Dumesnil, A.M., M.D., St. Louis.....	201	to the Sense of Sight. By M. A. Goldstein, M.D., B.Sc., St. Louis.....	207
Comparative Value of the Sense of Hearing.....		Clergyman's Sore Throat. By Price-Brown, M.D., Toronto.....	210

CLINICAL REPORTS.

Report of a Case of Epilepsy due to Nasal Obstruction. By Frank C. Todd, M.D., Minneapolis.....	212	Peculiar Accident in a Case of Intubation. By Norton L. Wilson, M.D., Elizabeth, N.J.....	213
Report of a Case of Bleeding from the Lingual Tonsils. By Hal Foster, A.B., M.D., Kansas City, Mo.....	215	Case of Large Papilloma, with Obstinate Hysterical Aphony. By A. B. Farnham, M.D., Milwaukee.....	219
A Perplexing Case of Tracheotomy for Foreign Body; Recovery. By Edward F. Parker, M.D.....	217	Dr. Thorne's Mastoid Retractor. By Chas. M. Paul, M.D.....	223
		Hay Fever; the Best Treatment for Stay-at homes. By William Cheatham, M.D., Louisville, Ky.....	225

CORRESPONDENCE.

229

EDITORIAL DEPARTMENT.

EDITORIALS.

To the Specialist.....	230	The Profession and their Journals.....	231
Look Before You Leap.....	231		

SELECTIONS FROM CURRENT MEDICAL PUBLICATIONS.

RHINOLOGICAL.

Sea Air and Diseases of the Nose.....	233	Suppuration of the Maxillary Sinuses Consecutive to Deflection of the Nasal Septum.....	235
Vaseline and Cocaine.....	233	Acute Empyema of the Antrum of Highmore: The Question of Self-healing.....	236
Cosmoline as a Haemostatic.....	233	Antidiphtheritic Serum in Ozena.....	236
The Relation of Chronic Diseases of the Nose and Throat to Disorders of Digestion.....	233	Ichthyol in the Treatment of Ozena.....	237
Torticollis Due to Adenoids.....	234	Eczema at the Nasal Entrance, in Children.....	237
Insanity and Headaches Due to Nasal Inflammation.....	234	Treatment of Hay-Fever.....	237
Reflex Nasal Headache Occurring During Pregnancy.....	234	Hay-Fever Acid Solution.....	238
Nasal Hypertrophy in its Relation to Ear Disease.....	234	Diffuse Papillomatous Degeneration of the Nasal Mucous Membrane.....	238
		The Sequelæ of Syphilis, etc.....	239

LARYNGOLOGICAL.

The Nerves of Taste.....	239	A Case of Tubercular Laryngitis on which Thyrotoxyd has been Performed.....	246
Disinfection of Sputa.....	240	Epithelioma of Soft Palate.....	247
Laryngeal Vertigo.....	241	Objects and Limitations of the Operations for Cancer.....	247
Intratracheal Medication.....	242	Surgical Interference in Malignant Disease of the Larynx.....	248
Hypnotism in the Cure of Stammering.....	243	Epithelioma of the Soft Palate Removed by Injections of Liquor Potassæ.....	248
Pyoctanin in the Treatment of Diphtheria.....	243	Adenitis of the Neck and Carious Teeth.....	249
Complications and Sequela of Diphtheria.....	243	Primary and Secondary Pharyngeal Tuberculosis.....	249
Delayed Paralysis after the Use of the Anti-diphtheritic Serum.....	244	A Case of Perichondritis of the Larynx.....	250
Varicella of the Larynx.....	244		
On Bony Growths Invading the Tonsils.....	244		
Skiasgraphy of Foreign Bodies in the Larynx.....	245		
Foreign Bodies in Throat.....	246		
Case of Obstruction of Larynx Due to a Web, 246			

OTOLOGICAL.

The Degenerate Ear.....	250	Chronic Otorrhea Permanently Cured with Trichloroacetic Acid.....	254
International Statistics of the Deaf.....	252	Pyrozone and Dilute Hydrochloric Acid in Suppurative Inflammations of Middle Ear.....	254
Boxing the Ears.....	252	Brain Abscess and the Middle Ear.....	255
Relation of the Thyroid Gland to Certain Diseases of the Ear.....	253	Case of Sigmoid Sinus Thrombosis.....	255
The Telephone and its Application to the Deaf.....	254	Sarcoma of the Base of the Skull, Involving the Ear.....	256

NEW INSTRUMENTS.

Hawkbill Nasal Scissors.....	257	A New Self-Retaining Nasal Speculum.....	257
A New Tracheotomy Tube.....	257		

SOCIETY PROCEEDINGS.

Mississippi Valley Medical Association.....	258		
---	-----	--	--

BOOK REVIEWS.

Books and Pamphlets Received.....	264		
-----------------------------------	-----	--	--



THE
LARYNGOSCOPE.

VOL. I.

ST. LOUIS, MO., OCTOBER, 1896.

No. 4.

ORIGINAL COMMUNICATIONS.

SYPHILITIC ULCERS OF THE PHARYNX.

BY A. H. OHMANN-DUMESNIL, A.M., M.D.

Professor of Dermatology and SyphiloLOGY in the Marion-Sims College of Medicine, St. Louis.

The syphilologist has been accused of seeing syphilis everywhere; and unfortunately he does see it in all manners, classes, conditions and ages of individuals so frequently and under such peculiar circumstances that he is never surprised to see the disease obtrude itself under the form of one manifestation or another. The cases are numerous in which the disease was never manifested or the patient never informed of what it was. In the former, lesions show themselves without any satisfactory history, and in the latter there is none at all. In either case the untrained observer will boldly rush to the rescue, ignorant of what he has to contend with, and powerless to render any adequate or material assistance. On the other hand, the trained syphilologist recognizes the trouble at once and brings relief of so marked a character, and in so rapid a manner, that his acts are looked upon as being but little short of the miraculous. These few preliminary remarks have been suggested by the fact that many self-styled laryngologists have failed to recognize syphilitic ulcers of the pharynx

which the writer recognized directly he saw them, and which he brought to a successful termination by a resort to proper local and general measures.

Syphilitic ulcers of the pharynx are by no means rarities. They occur with sufficient frequency to deserve more attention than has heretofore been accorded them. The ulcer may begin in one of two ways—either as a dark, brownish patch of the mucosa, or as a mucous patch. Whilst it may be true that these lesions do not invariably become ulcers, they do so sufficiently often to awaken an interest and lead to careful examination and adequate treatment. In all such cases there is a syphilitic angina of a more or less pronounced character which in itself demands good local treatment, supplemented by internal medication. As a rule, the first evidence of localization of the syphilitic process in the pharynx is neglected by the patient, and it is only later on when a certain amount of destruction of tissue has taken place that he seeks for relief. At the beginning there is a feeling of dryness of the throat, accompanied by some heat. The patient is continually hawking and succeeds in dislodging but a very small quantity of glairy, sticky mucus. Later on, when the epithelial covering of the mucosa is removed, some pain is felt at every effort at deglutition, and this pain is accentuated by hot or alcoholic drinks, and by highly seasoned food or a large bolus. It is at this time that relief is frequently sought. Some who are more careless permit the trouble to go on until an ulcer has declared itself, often of a serious nature and possessing marked destructive tendencies.

To go into a full and detailed description of all the varieties of pharyngeal ulcers of syphilitic origin would require more space than the limits of a short article would permit. The principal varieties which occur in the observation of those who devote themselves to laryngology are the superficial, the deep, the phagedenic, and the gummatous. In all of these varieties the ulcers may be single or multiple, and in the latter case they are usually situated close to one another, and soon coalesce to form one large irregular lesion. The mucous membrane seems to share this among other peculiarities which it seems to possess in common with the integument. As a rule these ulcers of the pharynx are single, and it is only in those who have a depraved constitution and broken down tissues that multiple ulcers are noted. Even then they are rarely of the same age, but appear one after another, and rapidly coalesce in forming a large, painful lesion.

The superficial ulcer resembles a mucous patch very closely, but differs from it in some essential respects. It is deeper and there is very plain evidence of the destructive process which is going on. The

contour is roundish or ovalish in form, as shown in Fig. 1, and the edges are more or less thickened and rounded on their edges. The sides are more or less sloping, and merely the basal membrane of the mucosa is attacked. On this account the spread is slow and centrifugal in a manner which is very regular. The floor of the ulcer is tolerably smooth, the secretion of pus being rather scanty and mixed with mucus. The ulcer is not a particularly painful one, but occasions much inconvenience on account of the muco-purulent secretion which is constantly forming. Care should always be exercised to prevent the spread of the lesion, which is apt to take place in a horizontal



FIGURE 1.

direction and implicate a comparatively large area. Another complication which may supervene, if the soft palate is very mobile, is for the velum to develop a similar lesion on its posterior surface through the apposition which sometimes occurs. Whilst this is quite an infrequent occurrence, I have had occasion to note it on several occasions, and it produces a condition of affairs rather difficult of successful management. Another disturbing factor is the prolongation of the duration of the trouble which it brings about.

In the deep, syphilitic pharyngeal ulcer we have a lesion which most frequently originates from a superficial one, or rather which begins as one apparently so. In a very short time there is marked destruction of the submucous tissues, and the process manifests itself not only in a vertical direction, but at the periphery as well. The borders become irregular, of marked thickness, and of a dark, brownish red. They are thickened and indurated, presenting a more or less denticulated contour. The floor of such an ulcer is more or less excavated, and is very irregular in the surface presented. Granulations are large, but pale and of an unhealthy appearance. They break down easily and do not seem to exercise much, if any, power in the furtherance of

healing. The general appearance of the lesion is given in Figure 2. So far as the surrounding mucous membrane is concerned, it is of a dusky red color, and is very typical of the syphilitic origin so much spoken of by syphilologists. The secretion is rather profuse and of a markedly purulent character. The destructive process not only manifests itself in a vertical direction, but spreads laterally until a comparatively large area is involved in the trouble. The process is not a very rapid one, but it is steady and is not only inconvenient, but soon becomes markedly painful. It occurs, as a general rule, in those

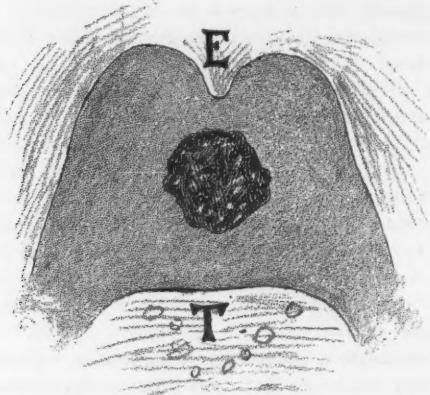


FIGURE 2.

individuals who have undergone insufficient or inefficient treatment, and in whom there has been a great amount of neglect in following the medication which was ordered. In addition to this we find other cases which have been at work to render the condition more aggravated, chief among which is an over-indulgence in alcoholics. It must always be borne in mind that what constitutes a moderate amount in one individual is excessive in another, and will proportionately work harm in the one case where it does but comparatively little damage in the other.

The syphilitic phagedenic ulcer of the pharynx is one which, like all processes of that nature, is extremely virulent and most rapid in its course of destruction. It spreads with lightning-like rapidity and involves all the tissues in an irregular fashion and has no tendency whatever to self-limitation, a peculiarity which is often noted in the two other forms which have just been noted. As would be naturally supposed it is of very irregular form and deep. The secretion is pro-

fuse and sanguinous, besides being somewhat ichorous. It has a great tendency to spread to the pillars of the fauces, and to attack the posterior wall of the velum palati, involving that structure in the destructive process. The great danger connected with this form of ulcer is its extension to the epiglottis, which is destroyed, and down into the larynx, producing ravages beyond repair and leading oftentimes to a lethal exitus. This form of ulcer is, fortunately, quite rare. It is only seen in hospital practice, and only then in those who have existed under the most depraved physical conditions. It is individuals besotted by drink, living from hand to mouth, who sleep in doorways and in the parks and on the highroads, and are total strangers to cleanliness, hygiene and proper food, who are the victims of this most destructive form of ulceration of the pharynx. As a rule, they exhibit external ulcers also, as an indication of the generally broken-down condition of their organisms. For such there is but little hope of bringing about an amelioration of their condition, as they cannot afford nor can public hospitals furnish them the proper means to obtain a perfect recovery.

The gummatous ulcer of the pharynx is one which is the result of either carelessness or of inefficient treatment. It always originates from a gumma of the pharynx, and unless this lesion be recognized and efficiently treated as soon as it appears a very ugly ulcer will result. As every one knows, the final stage of the gumma is ulceration, and when this occurs a rather large suppurating cavity is the result. In the pharynx but one occurs at a time, and it is a rather important matter to recognize the lesion, as, if it be permitted to go on, it may bring on a caries of the body of the vertebra over which it is located. Many cases of caries of the bodies of the cervical vertebrae have proven fatal or resulted in a certain amount of spinal paresis which could have been relieved had a proper diagnosis been made in time. In the gummatous ulcer there exists a lesion not larger than the little finger-nail, or perhaps as large as the thumb-nail, which is very deep in character and having slightly sloping walls. It is abundantly provided with granulations, and has a tendency to heal under the slightest encouragement. A rather reddish areola surrounds the ulcer, whose edges are somewhat indurated and have a tendency to curl outward. The pain is not excessive, but it is in proportion to the depth of the process. The secretion is a rather thick pus and rather abundant in character. As a rule, the contour is a very regular one, most often roundish, and occasionally ovalish. The floor is irregular, owing to the granulations and to the amount of destruction, which varies greatly even in different portions of one ulcer. At all times and in any event the gummatous

ulcer is one which should be closely watched, and, if possible, prevented by early and thorough treatment of the gumma. Gummata of the pharynx and of the palate are by no means rare, and the laryngologist should perfect himself in their diagnosis and treatment.

All of these varieties of syphilitic ulcers possess the peculiar fetor so characteristic of hectic destructive processes. But while they are all similar in the sort of smell they emit, they differ very materially in the matter of intensity. The more shallow the ulcer the less intense is the fetor, although at its best it is nauseating and disagreeable to the patient as well as to others. In those cases in which there is caries the stench is overpowering and nauseating to a degree. It is even more powerful than in cases of caries of the nasal bones of congenital syphilis. In order to mitigate this odor, those who possess it often resort to musk pastilles or equally strongly perfumed candies, and succeed in rendering the smell still more disagreeable. The only efficient method of getting rid of the foul breath is by means of thorough and efficient treatment.

I do not purpose taking into consideration the internal or general treatment which should be followed, as it would take up too much space. Suffice it to say that it should be very active and thorough, or else but short and unsatisfactory progress will be made. The local treatment differs in the different forms of pharyngeal ulcers of syphilitic origin. One general rule, however, may be laid down—the lesion should be thoroughly cleansed before any application is made or before operative measures are attempted. This is not only for the purpose of permitting applications to act better, and to have a clear field, but to prevent infection from the numerous pyogenic organisms which always swarm in these ulcers. The best detergent to employ is without doubt a bichloride solution, 1-1000, either swabbed or sprayed on the lesion. Having cleared it and cleansed it the application proper may then be made.

In the superficial ulcer a solution of acid nitrate of mercury in the strength of one to eight may be applied. Or nitric acid, C. P. is good if properly used, and the best method is as follows: A piece of soft pine wood of the size of a lead pencil is cut off square at one end. This is dipped in nitric acid, which is allowed to soak in the wood. The squared end is then placed against the ulcer which turns white. Very little pain, or none at all, follows such an application. The healing process sets in immediately, and one or two more applications at intervals of two or three days will suffice. The same treatment carried out in a little more energetic manner will prove equally valuable in the deep ulcer. Experience will show that neither nitrate of

silver nor chromic acid act as well, and, in addition, obscure the lesion. In the phagedenic form curettement should be employed, and then followed up with the nitric acid, more especially at the edges. When a gummatous ulcer is to be treated the sharp spoon should be used thoroughly; and if the underlying bone is involved it should be thoroughly scraped out. After doing this a bichloride solution of not less strength than 1-250 should be applied.

Such is a brief outline of the appearance and local treatment of pharyngeal syphilitic ulcers. Were it not for the limitations of space I would detail a few illustrative cases of different forms which have occurred in my practice.

COMPARATIVE VALUE OF THE SENSE OF HEARING TO THE SENSE OF SIGHT.

BY M. A. GOLDSTEIN, M.D., B.S.C., ST. LOUIS.

Professor of Otology, Beaumont Hospital Medical College; Consulting Aurist to the Alexian Brothers' Hospital, and to the Sisters of St. Joseph School for the Deaf; Aurist and Laryngologist to the Lafayette Dispensary, Etc., Etc.

The sense of hearing, being necessary to social intercourse, and not easily admitting of a substitute, stands in even a more intimate relationship to the intellectual life and spiritual education of mankind than the sense of vision with its recognition of form and color.

In the consideration of this theme it may be interesting to trace the relative importance of the two most prominent organs of special sense, the ear and the eye, in their physiological, anatomical and economic bearing to the general system.

Anatomically compared, there exists an analogy between the ear and the eye, which is truly remarkable, an analogy which is demonstrated in every detail of construction.

Membrana tympana versus cornea—ext. audit. canal versus iris—cerumen versus eyelash, cavum tympanum versus lens—optic nerve versus auditory nerve—labyrinth and organ of Corti versus retina and rods and cones—sound versus light. The comparison is endless. From a physiological point of view we note:

That there is only *one* stimulus which excites the optic nerve, *light*. If electrical, mechanical or other stimuli be applied to the optic nerve, *light* is the only sensation which is produced. Unaided, the eye perceives *color* and *size* only. The judgment of form and distance is only a matter of education, and cannot be accomplished by the eye alone.

Without the sense of *touch* the eye is absolutely powerless to convey

the impressions of form, weight, distance, thickness or density. The ear, on the contrary, performs all its functions unaided, and is more universal in its comprehension. Not only does it comprehend the *quality* of sound, but also the pitch, the intensity, and the distance at which the sound is produced.

The eye, deprived of the sense of *touch*, is left a comparatively much weaker organ; stripped of many of its important perceptions, which it is unable to perform without this valuable aid.

The ear, as is evident to all, works *unaided*, and the deprivation of any of the special senses does not lessen its power; on the contrary, it strengthens it and makes the hearing more acute. An excellent instance of this is in the blind, where, in many cases, the sense of hearing is very highly and keenly developed. In the blind the sense of *touch*, which is virtually the *accessory* organ to the sense of sight, becomes so highly developed, and so wonderfully sensitive, *as almost to act as a substitute for the eye*; and for the blind, the training and teaching can be so thorough as to almost substitute the delicate *touch of the finger tips for the sense of sight*.

Have you ever visited a school for the instruction of the blind—have you noted the school room filled with contented, peaceful faces—the hands of the pupils gliding noiselessly over the pages of their embossed-letter books, following the teacher attentively as he reads the lesson of the day; pupils, whose sympathies, whose interests, whose ambitions can be aroused by the sound of the human voice?

Have you ever been informed as to their rapid progress in scholastic work; of the brightness of their minds, the cheerfulness of their disposition, their love for music and the harmonies of sound, their ambition to become educated?

Let me now present *another* school-room picture—a school-room in an asylum for deaf mutes. The first striking comparison is the age of the pupils. Our blind pupils wear happy, young faces; here these deaf mutes seem prematurely aged; their faces lack expression; the teacher's labors are manifold, for the powers of comprehension of his pupils are blunt. They cannot hear the appeal and the influence of the mighty human voice. Alas! not only they cannot *hear* the human voice, but their *own power of speech* is gone. Either they have been *born* deaf and have never known what the human voice in all its grandeur *is*, or, in their deafness, its magnetic sounds have long since been forgotten.

So a *double* misfortune stares them in the face. They are both *deaf* and *dumb*; they may see, but it is with difficulty that they convey their impressions to others; they may taste or touch, but their limited development allows them but small opportunity for apprecia-

tion. Their progress is slow, and that fact in *itself* is an important consideration. For with that great opportunity of educational development, *reading*, it would seem that a great portion of intellectual advancement is in their grasp. Yet they *cannot* rise to the occasion, and that reading does *not* appeal to *them* as to a *healthy reader* is sufficient proof of their stunted faculties.

The influences which even *partial* deafness exert upon the intellectual development of a child are of paramount importance. The beginning and basis of all knowledge is the sense of experience. The impressions of external objects as they are carried by the senses to the brain furnishes to the intellect the materials for the foundation of ideas. The more acute our senses are, the more clearly and plainly our expressed thought; if, on the contrary, the sensitive perceptions are blunted, are partial and undecided, the entire nature and character of the individual will bear the stamp of incompleteness and uncertainty.

A young child cannot *read* expressed thoughts, but it can *hear every sound* of the ever-powerful human voice, and is always thrilled by its wonderful influence. There is nothing so impressive, so awe-inspiring, so commanding, so effective, exerting so strong an influence over the human mind, as the human voice; and there is only one way in which perception and conception of the human voice is possible—only one way by which the voice can reach and stir the human soul—and that is the ear.

Therefore deafness occurring in early life acquires a permanent influence upon the formation and development of the intellectual and moral nature. Such unfortunate children are not only unable to concentrate their attention, but they remain inattentive and fickle, while the want of an acute perception, which is chiefly attained through the ear, renders a connected train of thought and a comprehensive understanding very difficult.

At school these little unfortunates are subject to the constant ridicule of their classmates, and are continually reprimanded by their teachers for their inattention. Can you picture to yourselves for a moment the anguish and distress stirring the feelings of these little souls? This is true even of a moderate impairment of hearing; if, furthermore, there is a high degree or *total* deafness the calamity is indeed great and sad; for the child who does not *hear* the human voice does not learn to *speak at all*, or if older forgets the sound of the words, and in either case becomes completely *dumb* as well as *deaf*.

The blind are shown every compassion, every assistance, every sympathy; they are guided in every way, and are as a rule a happy, contented lot.

The deaf are left to stir for themselves, subject to the ridicule of their associates, ostracised from society, helpless in the articulation of speech, helpless in the perception of sound. They can communicate only with their own unfortunate associates or those trained in the use of their signs.

This factor alone — the comparative reception of the blind and the deaf by their fellow men — might be cited as a criterion, a standard, of society's judgment as to which is the greater misfortune.

The sway of musical sounds over the soul, the power of the spoken word, giving beauty and expression to thought, are forces appreciated by everyone open to the influences that make the cultivated man.

CLERGYMAN'S SORE THROAT.*

BY PRICE-BROWN, M.D., TORONTO.

The writer, in selecting this title for his paper, has done so on account of the still common practice among clergymen and general practitioners of applying it in all cases of chronic soreness of throat to which the former are liable.

By most of the older writers the term was confined to chronic follicular pharyngitis. Sajous, in his recent issue, limits it to laryngitis, while Bosworth ignores it altogether. Hence, being indefinite in meaning, ignored by some writers, differently defined by others, and the symptoms complained of being produced by a variety of diseases, it would be better for both lay and professional men to discard it altogether, and to name the throat disease on the basis of etiology.

A large majority of cases of chronic throat disease in clergymen arise from nasal or naso-pharyngeal obstruction of one form or another, and to cure the disease we must remove the stenosis.

The nose in a normal state performs the three-fold function of cleansing, heating and saturating the air of respiration before it reaches the throat; duties which can only be efficiently performed when nasal respiration is unimpeded. To produce this air saturation, the turbinateds throw out by transudation from 3xii. to 3xvi. of serum per diem. No other bodies possess the venous sinuses required to produce this supply, and consequently when nasal stenosis exists the scant pharyngeal moisture is quickly absorbed by the air, leaving a dry mucosa.

Oral breathing when established, in voice users particularly, frequently produces follicular pharyngitis, chronic laryngitis, or a boggy

*Abstract of paper read before Dominion Med. Association, Montreal, August, 1896.

infiltrated mucosa, singly or combined, and is often attended by the secretion of a thick tenacious mucus or muco-pus, the screatus required for the removal of which increases the pharyngeal irritation.

Hypertrophy and elongation of the uvula are also not infrequently the direct results of the irritation produced by this kind of breathing.

It is possible that the throat symptoms enumerated may sometimes arise by reflex action from digestive disturbances; but as a rule they owe their origin to nasal obstruction of one form or another.

The writer concludes by giving the history of ten cases of throat disease in clergymen, selected from a record of twenty-five. They were chosen as representative cases, all differing from each other as to cause, but all presenting similar throat symptoms. Four-fifths of them, or eighty per cent., owe their origin to nasal obstruction.

The treatment in all cases was the removal of whatever obstructions existed, followed by mild spray treatment during the process of healing, care being always taken not to excise too deeply, or to remove in any way the normal tissue. As a result, the throat symptoms in all cases improved, and in many disappeared.

The ten cases reported are epitomized as follows:

In one there was a large polypus in one nasal cavity.

In one a dislocated columnar cartilage.

In one a twisted or contorted uvula.

In one hypertrophy of the faucial tonsils.

In one ulceration in the left hyoid fossa.

In two there were septal ridges.

In two septal spurs.

In two catarrhal hypertrophies of the post-septum.

In two elongation and hypertrophy of the uvula.

In two pharyngeal granulations.

In three turbinal hypertrophies.

While in one only, the most hopeless case of all, and in which there was no hypertrophy anywhere, there was uncomplicated laryngeal disease.

CLINICAL REPORTS.

REPORT OF A CASE OF EPILEPSY DUE TO NASAL OBSTRUCTION.*

BY FRANK C. TODD, M.D., MINNEAPOLIS, MINN.

G. L., aged 17 years, a farmer's boy, was referred to the author January 8th, by Dr. Capps, of Ft. Worth. He had been suffering with epilepsy for about a month previous to the consultation; his attacks had occurred almost daily, and on several occasions he had had more than one attack in one day.

The fit was preceded by an aura, a feeling of faintness in his stomach, which sensation passed up into his head in the frontal region, when, as he expressed it, the sensation became a pain and "knocked" him down. These attacks usually lasted a half hour or more, after which he would sleep, as they always made him drowsy. He said he did not always become unconscious, but there is reason to believe that he was mistaken on this point.

He complained of having occasional headaches in the region of the temples and over the eyes, and also of slight dizziness. No other asthenopic symptoms could be elicited.

Examination of his eyes under hematropine revealed only .25 D. hypermetropia, and .25 D. hypermetropic astigmatism, axis 180°. The muscles were orthophoric. It could hardly be expected to obtain any beneficial results by the use of glasses, but it was thought best to try them, and the full correction was prescribed. Meanwhile, under Dr. Capps' directions, the patient was taking bromides and his attacks were lessened in frequency.

About a week after the glasses had been prescribed, he contracted a severe cold in his head, and suffered intense pain in the region of the frontal sinus; this pain was relieved by morphine, but his attacks returned with renewed vigor and frequency, always preceded by the

*Read before the Texas Medical Association, at Ft. Worth, Texas, May 1, 1896.

intense frontal headache, though no more stomach sensations were noticed.

While in the office one day during this period he had an attack, and particular attention was directed to all of his symptoms. The pain was agonizing and referred to the frontal sinus, more pronounced on the left side, which region was very sensitive to touch. After crying aloud from the pain for several minutes, he lost all power over his muscles and became entirely unconscious; the convulsive stage lasted but a moment, after which his muscles were relaxed and he remained as in a natural sleep, excepting that he could not be aroused. When he recovered his pain was gone, but the soreness still remained.

Subsequent examination of the nares revealed a large ecchondrosis almost completely closing the left passage. In fact, at this time, when the tissues were swollen, he was unable to breathe at all through his nostril. The post-nasal space was clear, but it is probable that adenoids had been present. He had been a mouth-breather, though there was good breathing space through the right side of his nose.

The diagnosis of frontal abscess, left side, and ethmoiditis was made. By the use of a spray of a four per cent. solution of cocaine the swollen tissues became so contracted that the pus could escape from the frontal sinus, and the inflammation and pain gradually subsided, so that in two weeks no soreness remained. With the subsidence of the inflammation the attacks disappeared.

An attempt was then made to cocaineize the tissues preparatory to removal of the tumor, but the patient showed a peculiar susceptibility to the use of a stronger solution of cocaine applied for a longer time, and the operation was deferred until a general anæsthetic could be given.

Accordingly, several days later, chloroform was administered, and the tumor was removed by the use of the saw. The next day an inspection back of the site of the operation revealed another smaller spur posterior and superior to one operated upon, and it was also observed that the middle turbinated body had become adherent to the septum, evidently as a result of old inflammation.

This last spur was removed by the use of a four per cent. solution of cocaine combined with carbolic acid, atropine and digitalin, a week later.

After the first operation he had but two attacks, and these occurred within a few days after operating, and were attributed to the pressure caused by the cotton tampons which had been used to plug the left nostril to prevent hemorrhage and adhesions. Since removing the cotton permanently he has had no attack nor headache. The bromides

were stopped, and he has since been taking only a tonic. He has gained several pounds and his general health is greatly improved.*

There have been quite a number of cases reported of epilepsy due to intra-nasal mal conditions, but in spite of this fact the text-books give the subject little attention, and most of them do not even mention it.

The peculiar idiosyncracy which the patient showed when a ten per cent. solution of cocaine was applied on a pledge of cotton is worthy of note. He dropped off to sleep while sitting in a chair, and though he could be aroused he would drop right off again. The stupor was very much like the effects of morphine, and it was impossible to keep him awake. Whiskey was administered and the patient was allowed to sleep off his stupor, as his pulse and respiration were normal and no alarming symptoms were manifested. This sleep lasted for several hours, and there were no after-effects.

No. 304 Dayton Building.

*In June the patient called last; he was working hard on a farm and enjoying the best of health, having had none of his former symptoms.

REPORT OF A CASE OF BLEEDING FROM THE LINGUAL TONSILS.

BY HAL FOSTER, A.B., M.D.,

Laryngologist to St. Margaret, All Saints, Missouri Pacific and Memphis Hospitals; Secretary of Western Ophthalmological, Otorhinolaryngological and Rhinological Association, Kansas City, Mo.

In 1877 Heyman called the attention of the medical profession to diseased conditions of the lingual tonsils. The base of the tongue is covered with lymphoid tissue, called lingual tonsils.

I trust that the report of the following case will demonstrate how necessary it is to understand diseased conditions of these tonsils. It will also show how much annoyance is caused thereby:

March 5th, 1896, Miss R., age 25, from western Missouri, was referred to me by my old friend, Dr. Willis P. King, of this city. She was a country school teacher. Family history good. The patient was pale; appetite poor; and was unable to sleep at night. The last month or two a hacking cough had annoyed her constantly. Her expression was anxious, and she presented all the appearance of a patient suffering with some incurable malady. There was pain on deglutition. She was in constant dread of being suffocated, and complained of a "tightness" of the throat. This condition had brought on neurasthenia. There was a constant desire to swallow. Three or four times daily, during the coughing, profuse bleeding would set in, which always frightened her greatly.

Her friends, as well as herself, had arrived at the conclusion that she would die in a few weeks of tuberculosis. In other words, she was almost a complete physical wreck. The lungs were found to be perfectly normal. On a careful examination of the nostrils, I found her to be suffering with hypertrophic rhinitis. This condition caused her to take cold on the slightest exposure or least change of temperature. Her throat was now carefully examined with the laryngoscope; the lingual tonsils were found to be very much enlarged. They were so badly irritated as to bleed when touched by a laryngeal cotton applicator. All the veins here were swollen, which accounts for the bleeding from her throat. In my experience, complete removal is the only remedy for this distressing trouble.

There are several methods of doing this, namely: chemicals, snares, knives, and the galvano-cautery. I have been in the habit of using the latter exclusively. In using the galvano-cautery great care should be exercised not to burn the epiglottis. The parts should first be made anesthetic by applying a 10-per-cent. solution of cocaine or eucaine.

After this treatment the patient will be obliged to take liquid diet for a few days. If great care is exercised the use of the cautery always gives rapid and brilliant results.

After explaining the difficulty to the patient and friends, and informing them as to the remedy, a 10-per-cent. solution of cocaine was applied directly to the diseased parts, and the galvano-cautery was applied with great care twice a week until each vein had been removed.

For the first week she was given milk, and antiseptic sprays were given frequently during the day. Tonics of iron and strychnine were given, and daily walks in the air. After the first treatment the bleeding and cough ceased, and with it the great anxiety left the lady. Sleeping was now a pleasure. Her appetite rapidly returned, and she gained in flesh, and walked to my office daily for two months. In her case the galvano-cautery was applied to a small place only at each treatment. This was done in order not to shock her too much or make the throat too sore. She returned home entirely well, and to-day is one of the most grateful patients I have ever treated.

In reporting this case I do not mean to say that the lingual tonsils always bleed when diseased. I do insist that in all obscure coughs or bleedings from the throat a careful examination should be made of these tonsils.

Dr. W. L. Dayton, of Lincoln, in *Journal of Laryngology and Ophthalmology*, October, 1892, reports cases. I am under obligations to Dr. J. C. Stewart for drawing the accompanying cut.

11th and Walnut Sts., Altman Building.

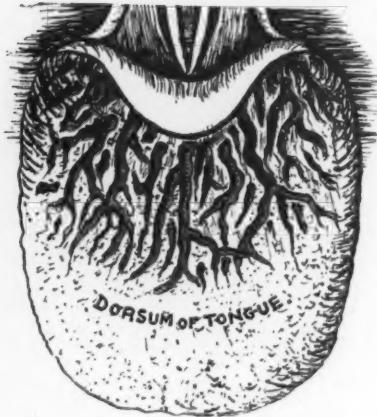


PLATE I.

Varicose Blood-Vessels at the Base of the Tongue.



A PREPLEXING CASE OF TRACHEOTOMY FOR FOREIGN BODY.—RECOVERY.

BY EDWARD F. PARKER, M.D.

Professor of Physiology and Assistant in Diseases of the Eye, Ear, Throat and Nose in the Medical College of South Carolina, Charleston, S. C.

On May 11th, C. B. C., a young child, fifteen months old, in perfect health and exuberant spirits, ran innocently to its mother with a jack-stone in its hand, and, on being told to give it up, ran as carelessly away, only to return in a few minutes gasping for breath and all the symptoms of impending suffocation. A doctor was immediately summoned, and arriving soon after the accident found the child's saliva tinged with blood, but after a careful digital examination of the throat could detect no foreign body. Emetics were given without any effect, and followed by several doses of castor oil, but no jackstone was found in the stools. On the next day its condition was promising, though its breathing was still labored. Towards evening respiration became more difficult, and for the first time the child refused to nurse. Becoming rapidly worse on the 13th, the patient was referred to me, and I saw it at 2 p. m. Its condition was then alarming in the extreme; cold extremities, cyanosed face, drowsy look, dull eyes, and noisy, difficult breathing. Chloroform was given and the throat, larynx and cesophagus examined with the laryngoscope as well as with the finger. Nothing abnormal was detected except some inflammatory swelling of the laryngeal aperture, which was hardly sufficient to cause such obstruction as appeared to exist. The dyspnoea increasing, I advised immediate tracheotomy, but the parents objecting it was agreed that I should make a visit later in the evening, prepared to operate if the symptoms still justified such a course. On reaching the house at 9 p. m. it was thought the child was dying, and an operation eagerly requested. On opening the trachea I passed a large probe up into the mouth and down to the bifurcation of the tube without meeting any foreign body. A tracheotomy tube was then inserted and gave such relief that the child, immediately on waking, began to nurse. All went well for a few days, when I noticed that some of the milk would pass out of the tube while it was taking the breast or would excite an attack of coughing with the same result. In drinking from a cup the mouth would be filled first and the milk slowly swallowed, and occa-

sionally a small quantity seemed to be regurgitated. Concluding from these symptoms that the jackstone was in the oesophagus I advised an exploration under anesthesia; but the parents would not consent, and in a few days to my surprise all signs of oesophageal obstruction disappeared. A diarrhea now began, characterized by dark green stools, and only subsided after a week's treatment.

The latter part of the month following the operation found the little patient improving in health, but though the tube was frequently removed for cleansing I had found it impossible to make the child do without it.

Every attempt brought on serious symptoms of asphyxia, and it would become livid, and the body bathed in a clammy sweat, so that I would reluctantly have to reinsert the tube. On July 14th the tube was at last removed, the wound closed quickly and there was a rapid improvement in the general health visible. On July 18th the child gave evidence of severe pain with each discharge from the bowels, and feeling sure that this was at last the jackstone, I carefully examined the rectum only to be again disappointed. This symptom gradually disappeared, and at this date, three months after the operation, the child is well and hearty, eating any kind of food, and only suffers from occasional attacks of short breath after exertion of some sort.

Some points in the above case appear to my mind very interesting. If the jackstone is in the digestive tract would not its presence have by this time been evidenced by some symptoms, dangerous or otherwise, referable to the abdomen? If, on the other hand, it was never retained in the body, what was the cause of such persistent and serious dyspnoea? The operation was urgently indicated on account of the asphyxia and entirely independent of the supposed presence of a foreign body. It is well known that foreign bodies in the upper part of the oesophagus may and generally do embarrass respiration either by direct pressure on the trachea or by reflexly causing some contraction of the glottis; but in this case the discontinuance of the oesophageal obstruction symptoms was not followed by any cessation of respiratory embarrassment. A case was recently reported of the successful removal of a jackstone located by the use of the X rays, in Philadelphia. I believe at the time the jackstone in question was swallowed we could not avail ourselves of this method of diagnosis. It was no doubt an error of omission in not exploring the oesophagus with a bougie on my first examination; but it teaches a valuable lesson, and my experience here will lead me always to examine both oesophagus and trachea notwithstanding such a preponderance of symptoms as may seem to implicate only the latter, as in the case related.

PECULIAR ACCIDENT IN A CASE OF INTUBATION.

BY NORTON L. WILSON, M.D., ELIZABETH, N. J.

Frank Reilly, age 3 years, came to my clinic at the Elizabeth General Hospital in September, 1894. Papilloma of the larynx was diagnosed, but owing to the smallness of the larynx it was found impossible to remove it through the mouth. The growth sprang from the right side of the larynx, just below the vocal band, and with forcible expiration could be thrown up between the bands. It grew rapidly,



FIGURE 1. Intubation Tube in a Tracheal Tube.

and tracheotomy was performed. The patient did badly under chloroform, but some days after this operation the remaining rings of the trachea and lower half of the larynx were split and the growth removed. This afforded only temporary relief; and several months after the first operation it was repeated, this time more thoroughly, but again the growth grew rapidly. An intubation tube was introduced for the purpose of making pressure. This was coughed out in a few hours, and I then resorted to the alcohol spray, which was faithfully used for four months; not finding the good result mentioned by Dr. Delavan, I again

introduced the intubation tube, using the 5-7 year old size. The boy is now 5 years old and it was my desire to introduce the largest tube possible. The tube was introduced after some little difficulty, and the head rested upon the vocal bands and apparently filled the larynx very well. The first time the nurse removed the inner tube of the tracheal tube (for that was allowed to remain) the laryngeal tube fell into the fenestra of the tracheal tube. You will observe from the cut that the intubation tube turned within the larynx so as to accommodate itself to the opening in the tracheal tube. It became so thoroughly engaged that it was impossible to extract it through the mouth. The upper end of the tube could not be felt in the larynx with the finger, but the extractor would slip down between the vocal bands and could be plainly felt to strike the metal tube. It could also be felt by the finger in the œsophagus through the muscular walls of the trachea. Fortunately the patient did not suffer much from dyspncea; but the tubes were becoming foul, and I determined to remove them through the trachea. The ring below the tracheal tube was split and two above it, and with but little difficulty the tubes were removed just as you see them in the cut. My only reason for reporting this case is as a warning to others who may not be so fortunate in having the patient survive. My only explanation of the tube dropping down is that the continuity of the lower part of the larynx was destroyed by the previous operation, and thus allowed the tube to slip down. The patient is still wearing a tracheotomy tube and still has the papilloma. I would be thankful to the profession if they can suggest any means to rid the boy of his tumor.

CASE OF LARGE PAPILLOMA, WITH OBSTINATE HYSTERICAL APHONIA.

BY A. B. FARNHAM, M.D., MILWAUKEE.

On March 2, 1894, N. B., nearly 14 years of age, consulted me. Family history showed father and mother died of phthisis. When ten years and six months old she had measles, on recovery from which she noticed a slight hoarseness. This rapidly increased, and in three weeks she could talk only in a whisper. Difficulty in breathing began later, and gradually increased until in November, 1893, respiration had become somewhat difficult. Her general appearance was anemic in the extreme; weight 45 lbs.; glands of neck enlarged, notably on the left side, head drawn to that side; breathing stridulous.

Mirror showed swollen arytenoids and an appearance like extensive ulceration between the swollen membranes. Unfavorable prognosis given. Immediately lanced the swollen tissues on the left side, with slight but instant relief. Next day lanced the right side, and then could see that there was a large growth of some kind apparently filling up the whole larynx. Removed with Mackenzie's forceps quite a mass of papillomatous growth. The blood running into the trachea caused me to suspend the operation. At the next sitting used my pharyngeal finger-nail and scooped out all I could reach. The fragments secured filled a drachm vial. The stump was treated with chromic acid fused on point of small applicator. The attachment was on under surface of left cord at anterior commissure.

Her breathing became normal, her cords perfect in action; but six weeks of treatment did not enable her to talk out loud, although she gained rapidly in flesh, became rosy-cheeked, active and vivacious. For a time I heard from her directly—no improvement in voice. Five months after, through a letter written to a nurse, I learned that while with a chorus of many children she found herself making as much noise as any of them. This was afterwards corroborated by the physician, who reported this year that she had no further trouble.

I report the case for what interest it may have. The using of the finger-nail and clearing the growth to the stump was a great satisfaction.

DR. THORNER'S MASTOID RETRCTOR.

BY CHAS. M. PAUL, M.D.

Resident Physician Cincinnati City Hospital.

During the last eighteen months a new retractor, devised by Dr. M. Thorner, of Cincinnati, has been used in all mastoid operations performed at this hospital. This retractor is a small, flat S-shaped instrument of steel or German silver, about one-and-three-quarters of an inch long, and about five-eighths of an inch broad. It presents a smooth, round, blunt ending at one extremity, and at the other is shaped into a three or four-pronged hook. (Fig. 1.) That used ordi-



MAX WOCHER & SON, CINC., O.

FIGURE 1.



FIGURE 2.

narily is this three-pronged retractor; but at times a special four-pronged anterior retractor is required. This is not only larger, but has also an important modification, inasmuch as that portion of the shaft bearing the four prongs is about one inch distant from the main body of the instrument, and is also considerably broader, as shown in Figure 2.* This special hook is used in all such cases where there is a large amount of tissue, together with the auricle, to be retracted anteriorly, as happens often because of great infiltration, or in the course of the so-called radical mastoid operation, when the auricle, together with the detached membranous auditory canal, are to be kept out of the field of operation. The prolonged shaft of this instrument, with its four prongs, dives into the depths back of the detached auricle, and readily takes a good and deep hold.

The instrument is used as follows: The incision having been made, the periosteum divided and turned back with a raspatory, the prongs

*The angle at which this four-pronged end is joined to the main body is in the latest pattern much more rounded than shown in the cut; it is about one-eighth of a circle.

of the retractors are inserted under the edge of the periosteum anteriorly and posteriorly (Fig. 3). Over the blunt end of the anterior retractor a strip of sterilized gauze or a narrow roller-bandage is now thrown, and the double strand carried across the forehead and around the head, and finally across the blunt end of the posterior retractor, where they are finally tied so as to fully retract the margins of the



FIGURE 3.

wound. Of late Dr. Thorner has occasionally applied the gauze strip across the root of the nose, but much oftener just below the nose, across the upper lip (Fig. 4), as in many, perhaps in the majority of cases, the conditions are more favorable to applying the retractors in this manner. In fact, this is one of the many advantages of this instrument: that the relative position of the retractors may be readily adapted to the individual conditions of the case, and, if occasion should require it, be changed at any time during the operation.

Other advantages of this useful appliance are the following:

1st. It holds the wound-margins apart more perfectly than can be done by any assistant. In all movements of the patient's head, whether made involuntarily by the patient himself, or in those made necessary by the operative procedure, the margins are held firmly and constantly apart. The hands of an assistant may become tired during these necessarily long operations and lose their hold; or a sudden movement of the patient's head, or a movement of the assistant himself, displaces the instrument held by him. The *largest* surface possible is thus *constantly* exposed to the manipulations of the operator.

2nd. It lessens the number of assistants required; sometimes the surgeon is not in the position to have a number of trained assistants at his disposal. But even then their work is rendered much easier if they need pay little or no attention to the retractors, and can devote all their attention to the other details. A most important point, however, is the fact that the small amount of room makes of necessity too

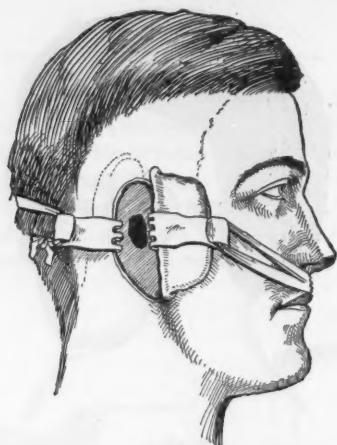


FIGURE 4.

many hands a source of annoyance and delay to the operator. Thus these retractors give to the operator the additional advantage of both light and room.

3rd. The retractors have a remarkable hemostatic effect, by completely controlling the oozing from the margins of the wound as soon as they are placed and the gauze strip is tightened up.

In conclusion, it may be said that the sharp prongs and their peculiar curve give them an absolutely secure hold. Should, however, a case require it, or whenever the operator prefers blunt retractors, the instrument may be readily reversed, and the blunt ends be used instead of the sharp hooks. If at any time the wound should need enlarging, or the gauze strip should become loosened, it can be tightened up in an instant by either being hooked upon the small finger of one of the assistants, or by placing a piece of rolled gauze between it and the head at any place where it is out of the way. These retractors can be sterilized, and are cheaper on account of their simple construction. And, finally, they can be and have been used in other surgical operations.

HAY FEVER: THE BEST TREATMENT FOR STAY-AT-HOMES.

BY WILLIAM CHEATHAM, M.D.

Professor of Ophthalmology, Otology and Laryngology in the Louisville Medical College,
etc., etc., Louisville, Kentucky.

"Hay Fever," as a name for the affection with which it is associated, is, we all recognize, a very defective one. I use it because I know of no better.

In the few remarks I propose to make upon this affection, I suppose all local causes of nasal stenosis and irritation to have been removed.

The cases I report will be mostly those that have been under my observation for one or more seasons, unable for different reasons to visit the usual resorts of "hay fever" sufferers, and who have had all forms of treatment with no permanent relief.

Mrs. H., married, housekeeper, age twenty-four years, no children, has had "hay fever" for six years. This is the third year I have treated her. The trouble began this year as usual, August 15th. I saw her August 17th. The nasal symptoms were well advanced, and the eye symptoms just beginning. As in the two previous years, in which she has been under my observation, I gave her syrup hypophosphites early in the summer. I gave her August 17th a small capsule of valerianic ether to prevent any ill effects from the cocaine solution with which I sprayed her nose. The cocaine, of course, shrinks all engorged tissue, and produces local anesthesia. I then twisted on a slender nasal applicator some absorbent cotton, and dipped it into a 50% solution of chromic acid; this I applied the full length of both inferior turbinal bones, the lower half of the middle turbinals, and the lower two-thirds of each side of the septum. In two or three minutes I washed the nostrils well with an alkaline solution, and sprayed them with a mixture of eucalyptol, camphor, cocaine (alkaloid), and vaseline. I gave her a wash to use so long as the secretion was excessive, containing aqua eucalyptol, aqua camphor, and distilled extract hamamelis, equal parts; under this treatment the symptoms were much worse that day, but better the next. This treatment occasionally has to be repeated once, very occasionally twice, during the season. I afterwards gave Mrs. H. valerianate zinc and extract nux vomica.

This treatment usually prevents the asthma and cough. Should the latter cause much trouble, I find nothing proves so harmless and so effective as codeine phosphate. So far this year she is quite comfortable.

Mr. G., railroad manager, had his first attack September, 1894. This year it began August 10th. I saw him first August 14th, 1896. His general health seems to be good. I found him suffering very much, unable to attend to his business, could not sleep at all, nose completely occluded, no asthma or cough, but his eyes disturb him very much. After cocaineizing his nose thoroughly, I found no hypertrophied tissue, but the nose very narrow and the turbinal bones very small. I made an application of a 25% solution of chromic acid and washed it out well in a few minutes with an alkali; then used the vaseline mixture in a spray. I gave him the same wash Mrs. H. is using, giving him also zinc phosphide and extract *nux vomica* internally. He reported next day much improved; had slept well. This improvement continued until Friday, August 21st, when he reported with an exacerbation; another application of the acid was made, since when he has been quite comfortable, attending his business without trouble. His eye symptoms persisted a few days, when I gave him acid boric, $\mathfrak{Z}ii$, aqua camphor and aqua rosa, $aa \mathfrak{Z}iii$, distilled extract *hammamelis* q. s. $\mathfrak{Z}viii$, as an eye bath; he used it in a glass eye bath four times a day and soon got relief. He complained of little or no discomfort from the acid.

Mr. G., a contractor, has had the above treatment for four years, with entire relief. Before I began treating him he had to leave the State every summer. I removed some hypertrophies from both nostrils and a ridge of bone the first year I treated him. Mr. G. works in a great deal of dust. He commences early in the spring, as he has mild "rose fever," on the zinc phosphide and extract *nux vomica*, and the wash of eucalyptol, *hammamelis* and aqua camphor. The acid application gives him one day of discomfort, after which he returns to his work in dust and dirt with no discomfort. He uses the eye bath also.

Mrs. H., married, weighs 253 pounds; has a baby about once a year; has asthma about one-half of the year; has violent exacerbations which can be relieved by weak chromic acid applications to the nose, and phosphate of codeine internally. During "hay fever" season Mrs. H. has one and sometimes two applications of the chromic acid, which give her great comfort. She uses the wash previously mentioned and valerianate of zinc; this latter I have been using in these cases for some years, with great benefit, I think; I sometimes give the three valerianates.

So far this season I have had but one patient, a Sister of Mercy, who has not gotten relief from the treatment given above. She came in late in the season, with asthma and a bad cough. I had never treated her before. Her nose is exceedingly contracted; healthy turbinals nearly produce total stenosis. With the slightest engorgement she cannot breathe through her nose at all. Cocaine will not reduce this engorgement now. I refer to the case as one impossible to relieve without the aid of surgery.

Only Sunday last—September 6, 1896—Mr. G., a merchant, who has just returned from a trip to Alaska, came to see me with an attack of "hay fever." This is the third year I have treated him. I made the chromic acid application, and have seen him twice since; he is much improved. It has always relieved him before.

September 1, 1896, Mr. S., of Augusta, Ga., called to see me, suffering intensely with "hay fever." I never saw a man more uncomfortable. No asthma, but head symptoms well marked. He has had "hay fever" for fifteen years. I gave him the usual treatment, and that same day he was called to New York on business. For four days and nights he was so uncomfortable he could neither eat nor sleep. He stopped all treatment, both local and internal. From a description of his symptoms he afterwards wrote me, he must have had mild sepsis. After the fourth day he began to eat. An extract from his letter, given below, shows the progress of his case from that date. His right nostril is nearly completely occluded by a deviated septum. I advised a correction of this.

Mr. S. writes September 9th as follows:

"I have not sneezed as many as half a dozen times in any one day. I have no itching sensation in the eyes, ears or nostrils, and I sleep at night without discomfort, and as a healthy man should do. I breathe freely through both nostrils; the discharge of clotted blood and mucus has greatly diminished, and the bleeding of the right nostril has almost entirely ceased. Ordinarily, this is the time that the fever is reaching its climax. I do not know whether it is coming back or not. It almost passes belief that I am free of it at this time."

For the asthma I have found ten or fifteen grains of bromide or salicylate of quinine at bedtime gives great relief. Also glyceride of hydriotic acid is very good. When there is a gouty element urotropine is of service. Mixtures containing lobelia, the bromides and the iodides are of much service; of course when the asthma is very severe, morphia and atropia act very promptly.

To summarise then, for "hay fever" sufferers who have to stay at home, I believe greatly in constitutional treatment, such as the valeria-

nates, the hypophosphites, zinc phosphite, anti-rheumatics, and in the correction of any gouty element.

Locally, the removal of all causes of nasal stenosis and irritation, with persistent cleansing with mild saline, acid and alkaline solutions. Just before, at the beginning, or in the midst of the season, I apply, as given above, chromic acid, and follow this with such medication as indicated in the body of this paper. But few of my patients have any discomfort, except for a few hours, from the treatment, which occasionally has to be repeated, and they are thus enabled to stay at home and attend to business with very little or no comfort. The chromic acid, as in Mr. S.'s case, sometimes gives great discomfort. Much of his discomfort, though, came from his neglect of treatment. Even with this four or five days of discomfort the result of the treatment more than counterbalances the many uncomfortable days of the "hay fever" sufferer, if a stay-at-home.

CORRESPONDENCE.

DENVER, COLO., Sept. 11th, 1896.

Editors The LARYNGOSCOPE:

Sirs—I feel that I have been taking up considerable space in your journal of late, but I want just a little more in which to reply to Dr. S. M. Payne, of New York, who has seen fit to criticise my motor nasal saw in your last issue.

I would state that while I may not have investigated all the saws on the market I have thoroughly tried Dr. Payne's.

I would like to ask Dr. Payne to drop into Tiemann's some day and ask to look at a Bosworth saw. The teeth of a Bosworth blade are not set forward, as Dr. Payne suggests, but they are set straight out from the edge of the blade and do not cut more when "pushing" the saw forward than when drawing it backward; therefore there is no tendency for the saw to hang or bend when in use. I can not say as much for Dr. Payne's saw, for I have given it many thorough trials, and I have always found that it hangs when drawn towards the operator. Of course it works perfectly easily when it is being pushed away from one, but when it is being drawn back it requires considerable effort, sufficient to pull the patient's head forward several inches. I have never had this to contend with when using the Bosworth saw. It has always run perfectly smooth in my hands.

As to Dr. Payne's criticism of my motor nasal saw, I would say that he has been theorizing, and does not speak advisedly. He says, "When the Bosworth saw is applied to the electric motor the danger of bending, hanging, and breaking is increased beyond estimation. I consider the electric motor with the above saw extremely dangerous."

Even the doctor's theory is wrong. The motor nasal saw has a forward and back movement of several thousand times per second, with the length of the stroke only an eighth of an inch; therefore it is plainly in evidence, that with such a rapid movement, and with such a short stroke, it is impossible for it to "hang, break, or bend," and practically it does not "hang, break or bend," but runs as smoothly and as evenly as it is possible for anyone to wish, and at the same time removes the spur in one-fifth the time required by hand, and with much less annoyance to the patient. I would, in conclusion, ask Dr. Payne to try this motor saw of mine and convince himself, beyond question, as to its utility.

G. MELVILLE BLACK, M.D.

EDITORIAL DEPARTMENT.

EDITORS AND PROPRIETORS.

FRANK M. RUMBOLD, M.D.

M. A. GOLDSTEIN, M.D.

ASSOCIATE EDITORS.

M. D. LEDERMAN, M.D.
New York.

W. SCHEPPEGRELL, M.D.
New Orleans.

S. SCOTT BISHOP, M.D.
Chicago.

F. B. EATON, M.D.
San José, Cal.

FOREIGN EDITORS.

DR. J. DUNDAS GRANT,
London.

DR. J. J. KIRK DUNCANSON,
Edinburgh.

DR. J. K. KIMURA,
Tokio.

DR. FREDERICK SEMELEDER,
Vera Cruz.

DR. VICTOR URBANTSCHITSCH,
Vienna.

DR. A. HARTMANN,
Berlin.

DR. J. STERLING RYERSON,
Toronto.

DR. GOTTLIEB KÜER,
Copenhagen.

ORIGINAL ARTICLES for publication should be in the Editorial Office on the 5th of the month preceding date of publication.

ILLUSTRATIONS necessary to elucidate the text will be furnished without expense to authors when suitable ink drawings or photographs are furnished.

SUBSCRIPTION price, \$2.00 per annum in advance. Foreign countries, within the Postal Union, \$2.25.

CONTRIBUTORS to THE LARYNGOSCOPE who desire reprints will please communicate with the Commercial Printing Company, 318 N. Third Street, St. Louis, Mo., stating the number they wish, at the same time that they forward the MSS. to the Editors.

COMMUNICATIONS and all drafts and money orders should be addressed to

THE LARYNGOSCOPE,
P. O. Box 787, St. Louis.

EDITORIAL.

TO THE SPECIALIST.

THE LARYNGOSCOPE has now passed the experimental stage, and is an assured success. Generous responses have been received from all parts of the country, and the editors feel that they have the support of the profession in their undertaking.

We mail this number to all specialists whose names we have, and earnestly request them to aid in making THE LARYNGOSCOPE the American exponent of their specialty. While there are still about two thousand who have not responded with their subscriptions, we feel sure

that their interest has been awakened, and we earnestly request all such to fill out the blank on advertising page 9, and send it to this office. Help the undertaking along by sending your own subscription and by influencing your professional friends to subscribe for it.

LOOK BEFORE YOU LEAP.

The danger of rushing in where wise men refuse to tread is as proverbially true as a leap in the dark. Yet we who practice the special branches of medicine are almost daily examples of the violation of both proverbs. The danger of attempting to remove foreign bodies from the ear on hearsay evidence of playmates or friends, without verification by proper examination of the aural canal, has been strikingly brought home to me by cases which have come under my observation during my professional life. Some years ago a child was brought to me from a distant town, with the statement that she had put a glove-button in the ear, and that the local physicians had made vain efforts to remove it, and that they had only succeeded in removing some *tiny pebbles*, which the mother did not know were in the ear. An examination showed that the drum-membrane had been almost entirely removed, and with it the *ossicles*.

There was no trace of a button. It is a great question in my mind if a button was inserted in the canal. Here was a case in which a child's hearing was entirely destroyed by gross carelessness in neglecting to properly examine the part. Fancy anyone groping in the dark for three hours, as was done in this case! Yet there are those among the general profession who look with disfavor upon aurists as persons who perform some sort of incantation and ask a large fee. How much more honest it would be, and how much it would raise the profession in the eyes of the public, if when placed in charge of such a case as the one above narrated the physician, if he were not skilled in the use of the head-mirror, would say: "I do not understand this case; send for an aurist." Want of common honesty brings its own punishment, in the shape of loss of public support and confidence.

G. S. R.

THE PROFESSION AND THEIR JOURNALS.

Many professional men seem to grudgingly pay their subscriptions for their professional journals, yet never hesitate to pay promptly for their secular magazines or daily papers. Why this is so is hard to understand. Their college education, instruments, books and profes-

sional publications constitute their stock in trade or capital invested in their business, if it will be permitted to call the pursuit of their profession their business.

It is their duty to their clients and the community in which they reside, and it is to their own pecuniary interest to increase their invested capital as much as possible. How can this best be done? By investing in new and improved instruments and appliances, and by purchasing and reading the so-called standard works and by subscribing for as many good professional periodicals as possible.

The worth of a standard work, after it is read, is in its use as a book of reference. The object of the periodical is to give the reader the current thought of his profession, and its worth is measured by the extent of the field from which it draws its contents and the character of its contributors.

In our profession many object to paying from two to five dollars for a periodical because, they say, it costs too much, or there are not enough articles published in it that benefit them in their practice. If this man is conscientious in his desire to gain increased knowledge of his profession, either for the sake of knowledge itself or so that he can better palliate or eradicate the trouble for which his patient consults him, he should feel that his journal has paid him provided he only receives *one* practical thought or *one* hint during the course of the year that assists him in the better handling of a case, or mayhap to save a life. Will not his extra fee, not to mention other cases that will consult him on account of his success in this particular case, more than pay him for the investment made?

Put this proposition on a business basis: is it not the act of a shrewd business man to invest \$5 in order to draw, perhaps, \$100 in dividends.

Too few of the members of our profession take this into consideration.

SELECTIONS FROM CURRENT MEDICAL PUBLICATIONS.

RHINOLOGICAL.

Sea Air and Diseases of the Nose.

M. Larraud (*Arch. Intern. de Lary., Rhin. et d'Otol.*) claims that sea air is beneficial in all affections of the nose that are not acute.

Vaseline and Cocaine.

Dr. C. E. Sage (*Pharm. Jour.*) states as the result of experimentation that cocaine is not soluble in either vaselin or lard, but is found to be soluble in castor or olive oil.

Cosmoline as a Haemostatic.

Dr. E. B. Gleason in an editorial in the *Atlantic Med. Weekly*, on Recurrent Nose Bleed and the Control of Nasal Hemorrhage, states that he considers fluid or solid cosmoline to be a better haemostatic than any of the iron salts.

[It has been my practice to always spray the nasal cavity, after a bur or saw operation, with vaseline as hot as can be borne by the patient. No matter what the amount of hemorrhage, this has always promptly checked it.—EDITOR.]

The Relation of Chronic Disease of the Nose and Throat to Disorders of Digestion.

In giving due insight to the direct excitants in causing pharyngeal disease (Thorn R. French, M.D., Brooklyn, *N. Y. Med. Journal*, Sept. 12, 1896,) the writer nevertheless believes that the great majority of such sufferers are the subjects of some derangement of the gastro-intestinal tract. He attributes this to the American habit of hasty and irregular eating. In a considerable number of individuals examined by him, all but a very few had evidence of some pharyngeal trouble, associated with disturbed digestion of the stomach and intestines. He lays stress upon the importance of giving this portion of the economy deserving recognition in patients presenting themselves for local treatment.

M. D. L.

Torticollis Due to Adenoids.

Dr. A. J. Gillette (*N. Y. Med. Jour.*) reports two cases of torticollis cured and one relieved by appropriate operation for the removal of existing adenoids.

Insanity and Headaches Due to Nasal Inflammation.

Dr. J. H. McCassy (*Cincin. Lancet-Clinic*) says that as a result of his observation in the examination of about eight hundred cases, several times a week, in the Kansas State Insane Asylum, he is convinced that hypertrophies, vaso-motor rhinitis, polyps, deflections of the septum, chronic inflammation of the ethmoidal, frontal and maxillary sinuses, etc., are frequently the cause of headache, and in not a few cases of insanity.

Reflex Nasal Headache Occurring During Pregnancy.

Nasal headaches occurring during pregnancy, writes Dr. J. A. Mullen in the *Southwestern Medical and Surgical Reporter*, are peculiarly harrassing and painful. "These headaches are, as a rule, intense, occurring on one or both sides of the head, sometimes starting as a supra-orbital neuralgia, and at others as a temporal migraine, either of which finally spreading and involving all the branches of the fifth pair of nerves. They are fortunately not incessantly severe, but begin rather slowly and steadily, reaching a maximum any hour of the day or night, and lasting for a long or short period. They are generally ushered in by an acute coryza, and in my observation, without treatment, the acute cold rarely progresses beyond the stage of proliferation until the pregnancy is ended. They show very little disposition to terminate by resolution. Quite frequently there are associated symptoms of hay fever or asthma. The nasal mucous membrane is greatly engorged and softened, and the inflammatory appearance much less than the size of the swollen membrane would seem to indicate; in other words, the condition simulates an angioneurotic œdema in all but its clinical history. The nasal secretions are profuse, with occlusion of the nasal chambers, and as a result mouth-breathing is substituted for nasal-breathing. The secretions of the mouth and pharynx are likewise abundant. The headaches more commonly occur about the fifth month of pregnancy, but many attack the primipara or multipara at any time during her *enciente*."

Nasal Hypertrophy in its Relation to Ear Disease.

MacNaughton Jones (*Annales des mal. de l'Oreille*, vol. 22) concludes, as the result of long observation and careful investigation, that hypertrophies of the turbinates as etiological factors of deafness, pre-

sent a smaller percentage than would appear probable at first. An examination of 300 cases of aural disease, revealed only 69 hypertrophies of the turbinates and 18 deviations of the septum; in only 25 per cent. of the cases, therefore, can nasal obstruction be regarded as causing deafness. He lays stress on the too frequent and too severe treatment directed toward hypertrophy of the turbinated bodies for the relief of deafness, and cautions against too free an application of the cautery and snare in the consequent turbinectomy.

Suppuration of the Maxillary Sinuses Consecutive to Deflection of the Nasal Septum.

In the *Rev. Internat. de Rhin., Otol., et Laryng.*, Dr. Augieras details a case of suppuration of the right antrum of Highmore in a man forty years of age, the septum of the nose being strongly deflected to the left side. This inflammation of the maxillary sinus, after existing for many years, had given rise to alveolo-dental periostitis.

Acute Empyema of the Antrum of Highmore: The Question of Self-healing.

During the last few years the literature of chronic empyema of the antrum of Highmore has been exhaustive and profuse, but little has been said upon the subject of acute empyema; yet this form must be the more frequent of the two. Most of the cases, however, doubtless remain undiagnosed, both by reason of insufficient familiarity with the symptoms on the part of the profession, and also on account of negligence of patients who, unless the disease is very severe, let it pass as an ordinary acute cold in the head. Dr. Avellis, Frankfort-on-the-Rhine (*Archiv für Laryngol. und Rhinol.*, bd. iv, heft 2), describes two grades of acute empyema—the light and the severe form. In a case exemplifying the former variety the patient was examined fourteen days after having contracted a severe cold, great occlusion of the nostrils having developed six days after exposure. On examination a streak of pus could be seen crossing the median line of the septum above the inferior turbinated body; and upon washing out the antrum through a perforation made in the inferior meatus, pus was obtained. There was no pain in the region of the antrum—only an uncomfortable pressure in the nose. The patient recovered spontaneously in the course of from two to three months. In this case influenza seemed to bear no etiological relation to the empyema, although influenza is a common cause of acute inflammation of the antrum. The characteristic symptoms of the light form include pain upon pressure and a sense of tension within the upper jaw, and an irregular, purulent, oftentimes bloody discharge. The pain is intensified by sudden move-

ments of the head, cough, etc. Ofttimes there arise slight edematous swellings of the cheek and eyelid; sometimes the edematous part is reddened: Supra-orbital pain is rare. A foul odor may or may not be present.

The severe form of the disease presents all of these symptoms, and in addition others of greater gravity, as related in the case of a patient, a physician, who became ill with influenza, suffering from dizziness, vomiting, loss of appetite, cold in the head, headache, and backache. Six days later he had a severe pain in the left upper jaw, which was transmitted to the top of the nose and to the forehead, and which gradually increased until the patient was confined to bed. There was tenderness on pressure over the antrum and upon the ball of the eye, with the sense of smell suspended, and a profuse discharge of pus. The temperature varied in the evening from 101° to 102°. The author calls special attention to the edematous swelling of the cheek and of the eyelid, which varies in extent, but is to some degree nearly always present, and which is a valuable diagnostic sign. A few days later the patient became delirious and his speech incoherent, the end of a sentence being frequently forgotten. The examination was made about two weeks from the beginning of the affection. Both sides then seemed to be involved, and the diagnosis was rendered certain by a puncture through the inferior meatus upon both sides, when pus was obtained by syringing. There followed immediately thereafter mitigation of the symptoms, and in the course of a few weeks the patient had entirely recovered. One antrum was washed out several times, the other once only. In this severe case the evacuation of the pus seemed necessary to recovery. In the lighter forms of the disease, although the author has usually washed out a single time for diagnostic purposes, he thinks recovery will take place spontaneously. In his observation, only one case in ten assumes the chronic form.—*Medicine.*

Antidiphtheritic Serum in Ozena.

Cozzolino (*Gaz. degli Ospitali; British Med. Jour.*), in a clinical lecture on this subject, speaks strongly against the supposed cures of ozena by means of serotherapy (that is, by the use of antidiphtheritic serum). He believes that the part played by microbes in this disease as distinguished from pseudo ozena is much less than certain writers would have us believe. On the other hand, the condition of the nasal mucous membrane is all-important, and the author's treatment is directed toward this, and not to any microbial agency. If the soil is healthy, microbes do no harm. The only radical treatment, in the

author's opinion, is surgical, and should be directed toward the production of a "sclerogenous" condition; that is, the diseased parts should be freely scraped and scarified, as one would treat a lupus, so as to produce a healthy scar surface.

Ichthyol in the Treatment of Ozena.

Our Vienna confreres (*Sémaine Med.*, August, 1896) have been very successful recently in the treatment of ozena with ichthyol. It is claimed that the fetid, offensive breath can be more rapidly and completely removed by ichthyol than with any other known remedy. After first cleansing thoroughly with some alkaline solution to remove the crusts and inspissated mucus, the nasal cavities are flushed with a 2 to 5 per cent. aqueous solution of ichthyol, taking all precautions to avoid the disagreeable features of the nasal douche. A cotton applicator, supplied with a 25 to 30 per cent. solution of ichthyol, is then applied to the mucous membrane of the affected areas, both anterior and posterior nares being thoroughly swabbed. It has also been recommended in the treatment of pharyngitis sicca.

Eczema at the Nasal Entrance, in Children.

Vohsen (*Memorabilien*) recommends the application of borolanoline after cleansing the nose.

Treatment of Hay-Fever.

W. W. Bulette, in the *Medical Fortnightly*, Sept., 1896, calls attention to the fact that in a disease presenting such a variety of symptoms it is impossible to lay down fixed rules for treatment, but each case must be managed on its own merits. The first important step is careful regulation of the diet, a mixed one being preferred, in which neither the nitrogenous nor carbo-hydrate elements predominate; all excesses are to be held in abeyance; alcoholic stimulants absolutely forbidden, and often a change of occupation is to be recommended.

The morbid lesions of the nasal cavities should next receive attention, whether it be a deflected septum, exostosis, enchondrosis, polypus or hypertrophy and vascular turgescence of the turbinated bodies; in young patients adenoid vegetation and enlarged tonsils should not be overlooked.

To achieve the best results, treatment should begin from six to eight weeks before an expected attack. B. does not believe it good surgery to perform a radical operation in the nares during the exacerbation of this affection, as the proper conditions for good surgical repair are wanting when engorgement is so great. If the case comes under observation during the attack, we can only palliate the trouble.

Trichlor-acetic-acid or the galvano-cautery have often proven of great benefit. Deep cauterization and wholesale destruction of the mucous membrane cannot be too strongly condemned. In the majority of cases the posterior two-thirds of the inferior turbinals and the septum are the most sensitive areas, and failure often results from local applications simply because these areas are not reached.

In addition to alkaline sprays for cleansing, the author recommends various astringents by atomizer or nebulizer. Internally, conium hydrobromate gr. $\frac{1}{2}$, ammon-chlorid gr. $\frac{1}{2}$, pulv. opii, extr. belladonna, and extr. aconit., of each gr. $\frac{1}{16}$, given every two or three hours, will often allay the irritability of the nasal passages and stop excessive secretion.

The indiscriminate use of cocaine sprays is emphatically condemned. Certain it is that we cannot eliminate to any extent the third factor in the causation of the affection, namely: mechanical irritants in the atmosphere. We can, however, build up the nervous system, place the respiratory mucous membrane in a healthy condition, thus rendering the individual less vulnerable, and prevent susceptibility to the action of the irritants in the atmosphere.

Hay Fever Acid Solution.

Dr. W. F. Strangway uses:

R. Acid Acetic.....	Mij.
Sodium Chlor.....	grs. iv.
Resorcin.....	grs. liiss.
Aqua	3j.

Sig. M. Use as a douche.

In addition he gives internally one to two drachms hydrochloric acid daily.

Diffuse Papillomatous Degeneration of the Nasal Mucous Membrane.

Though of not frequent occurrence, instances of this affection are at times observed (G. Hunter Mackenzie, M.D., Edinburgh, *The Lancet*, 3807). In this case the patient, a male, 30 years of age, gave an alcoholic history, but no syphilis. The mucous membrane of both nostrils was covered throughout by numerous sessile growths, varying in size from a pin's head to a grain of rice. They were most abundant in the upper regions (roof, outer wall, and septum). The inferior portion of the nose was also affected. They were removed with the cold snare and nasal curette, and showed no recurrence after an interim of four months. The microscopic examination revealed true papillomatous degeneration.

M. D. L.

The Sequelæ of Syphilis, etc.

In a report of a case seen by the author (Dr. Chas. H. Knight), difficulty of arriving at a correct diagnosis is vividly portrayed. The patient was a young girl, 15 years of age, who presented herself for treatment on account of epiphora. The nasal duct was found obstructed at its nasal orifice by an enormous enlargement of the right inferior turbinated body, which completely occluded the nostril and was adherent to the septum. The mass was removed with snare, but rapidly resumed its original size. Malignancy was suspected, and a microscopical report, a second examination, said it was a small round-celled sarcoma. A surgeon was consulted, and he recommended excision of the upper jaw. Ten days later a sensitive swelling on her left shin was discovered and the patient was put upon the mixed treatment in ascending doses. Within two weeks the swelling, together with the nasal tumor, had entirely disappeared. The author justly remarks, that the case narrowly escaped going on record as one of sarcoma cured by excision of the upper jaw. Such experience impresses us with the importance of placing all similar cases upon mixed treatment before attempting surgical interference.

In the treatment of saddle nose, the "Martin" bridge is mentioned as being of service to correct the deformity. It is made of platinum, with lateral arms to be imbedded in the superior maxillary bones. The length and shape of the bridge must be adapted to each case. Dr. Hopkins has modified same by making it out of a single piece of metal. It is placed in position through a Rouge incision. Care must be taken not to allow too much pressure upon the bridge, otherwise ulceration and perforation of the soft parts will occur, as happened in one of the author's cases. An "armless" bridge is also of service, in cases where the only partial destruction of the cartilage has resulted. These may be introduced through a median incision over the dorsum of the nose.

M. D. L.

LARYNGOLOGICAL.

The Nerves of Taste.

L. von Frankl-Hochwart (*Wiener klin. Wochenschrift; International Med. Magazine*) says the lingual nerve supplies fibres for the sense of taste to the anterior two-thirds of the tongue; these pass entirely or for the greater part into the chorda tympani. Clinical observation of processes situated at the base of the brain proves that

these fibres enter the fifth nerve; resection of the Gasserian ganglion very often causes ageusia in the anterior portion of the tongue. It is not known whether these fibres of taste are to be found in the second or third branch of the fifth nerve, and the mode of connection with the facial and chorda tympani is unknown. The glosso-pharyngeus is generally recognized as the nerve of taste to the posterior third of the tongue. In some individuals, however, total destruction of the trigeminal nerve by basal growths, trauma or resection does not interfere with the sense of taste, and probably the glosso-pharyngeus supplies in these cases the entire tongue with taste fibres. Although repeated clinical observation of cases in which the ninth nerve was destroyed has shown alteration of taste only at the posterior part of the tongue, Popl, in his case of compression of the left glosso-pharyngeus by an aneurism, as demonstrated by the autopsy, without involvement of the fifth, was able to observe considerable disturbance of taste in the anterior part of the tongue as well as total ageusia over the left posterior position.

Disinfection of Sputa.

Dr. E. F. Woods, of Janesville, Wis., read a paper before the Wisconsin Medical Society (*Charlotte Med. Jour.*).

In the report of the Commission appointed by the Congress of Tuberculosis, read before the Academy of Medicine at Paris, July, 1889, we find the following:

"Of all the agents of transmission of tuberculosis, the sputa is the most formidable. There is danger to the public in discharging the sputa upon the earth, carpets, hangings, curtains, napkins, handkerchiefs, clothes and coverings. Not dangerous while moist, it becomes when dried the chief means of the spread of the disease.

"How can we prevent this? One of the eastern States has tried to solve the question by legislative means, prohibiting all spitting upon the floor of public conveyances and places of resort.

"This is a move in the right direction, but one difficult to carry out. Besides it only touches part of the question. Spitting upon the earth, etc., remains.

"The one thing we can do, as physicians, is to use all our influence and authority over tuberculous patients.

"Sick people are selfish and care little for the welfare of others. But we may use as a potent argument the danger of self-inoculation. An individual well on the road to recovery, unless he takes care of the sputa, greatly diminishes his chances of recovery.

"We must persuade him, when at home, to use a cuspidor in which

it is well to keep a solution of bichloride; this should be emptied daily into the fire, and then well washed out with boiling water.

"In these days of steam heat, gas stoves, etc., this often becomes difficult, and if obliged to empty into sewers be sure a solution of bichloride is always used.

"Never empty upon dust-heaps, into the garden or latrines, where it may become a source of infection to animals as well as man.

"When away from home, he should carry a small spit-cup containing a slip of absorbent cotton or gauze wet with bichloride solution, to be emptied as often as possible.

"Warn him, and also his relatives and friends, especially of the danger of spitting into handkerchiefs.

"Sometimes, when the patient has reached the latter stage of the disease and is confined to bed, the exertion of moving to spit into cuspidors, etc., causes pain or severe attacks of coughing. In such cases I have found it very convenient to keep a pad of toilet paper at hand and allow the patient to spit into pieces of this, dropping them afterwards into the cuspidor containing the bichloride solution.

"Legislation cannot accomplish what we wish; the influence or authority of the physician often is of no avail, and we may eventually be obliged to quarantine—reporting cases of tuberculosis as we do of diphtheria.

"This would be unnecessary if we could only arouse the general public to a sense of its danger and have its assistance and influence to aid the physician."

Laryngeal Vertigo.

Knight (*Int. Med. Mag.*, June, 1896) thinks that "laryngeal vertigo" (Charcot), "spasm of the glottis" (Kinshaber and McBride), and "laryngeal epilepsy" (Gray) are unfortunate names to apply to these cases, as in most of them there is no true vertigo and no evidence of glottic spasm, and may present no evidence of epilepsy. The factors concerned in producing the condition are different in different cases, so that a satisfactory name is difficult. Taking a comprehensive view of the recorded cases, we find that the cerebral condition can sometimes be described as syncope, which has been produced by disturbed cerebral circulation, such as we have from long-continued breathing, and sometimes it can better be described as an exhibition of "*le petit mal*." In some cases there is not the slightest evidence of epilepsy, and in others we find convulsive movements of the limbs, head, face, and in a few cases mental confusion after the attack. We find, also, that there is a predisposition to syncope or "*le petit mal*" in these

cases, as shown from their occurrences from other than laryngeal causes. Again, the exciting causes are various, and we may have only to do with excitation originating at the glottis; this may be due to different conditions, organic or functional. He calls attention to Sommerbrodt's case, which was cured of epilepsy by the removal of a pediculated polyp of the larynx. Spasm of the glottis, or the rapid succession of the closures of the vocal cords in coughing, may produce loss of consciousness by disturbance of the cerebral circulation. The author relates the case of a man aged 54, who took cold the latter part of September, and had a cough to November; when he saw him the patient had had a dozen attacks of loss of consciousness after fits of coughing, none of the spells of coughing being severe; one of the attacks was not preceded by cough. At times he had twitching of the face and limbs without loss of consciousness. Examination: nothing marked in the larynx. Moist rales at base of left lung; pulse 80; very weak; first sound of heart also weak, suggesting degenerative disease. He thinks that attacks in this case were due to syncope from a weak heart, which any disturbance like coughing might bring on, though the muscular twitching suggested nervous irritability also. The points to which he invites attention are: 1. That cases of loss of consciousness after cough are not all produced in the same way. 2. That the cerebral condition may be due to syncope or *le petit mal*. 3. That there is a general predisposition to one or the other of these conditions. 4. That the exciting causes are various, sometimes organic or functional.

W. S.

Intratracheal Medication.

Dr. J. L. Barton, in an article in the *Med. Record*, reports having treated twenty-five cases by intratracheal injections, including cases of severe laryngo-tracheitis, bronchitis, and tuberculosis, and one case of asthma. He cites as the advantages of this form of medication:

- “1. The remedy is applied directly to the irritated mucous surface.
- “2. It immediately alleviates the most distressing symptoms, adding at once to the comfort of the patient.
- “3. In a certain number of cases the antiseptic effect of the medicine is very pronounced, as shown by the longer interval between the febrile attacks and by their lessened intensity, when they do occur.
- “4. The tracheal and bronchial mucous membrane rapidly absorbs the medication, so that we may expect a general as well as a local effect.
- “5. We avoid disturbing the patient's stomach with nauseating doses and the shattering of his nervous system with opiates.
- “6. This method of alleviating the most distressing and annoying

symptoms does not interfere in the slightest degree with any other line of general treatment which may be deemed advisable.

"7. In cases characterized by an atrophic condition of the tracheal mucous membrane or of pulmonary disease with cavitation leading to retention and decomposition of the secretions, intrabronchial injection will remove the disgusting fetor of the breath consequent upon this condition."

The remedies employed should be soothing and the vehicle non-irritating, the preferable vehicles being the petroleum oils.

From one-half to one drachm may be injected at each insertion of the tube, and this may be repeated at one sitting until from two to four drachms have been used.

Hypnotism in the Cure of Stammering.

Thomas B. Keyes, in the *Columbus Medical Journal*, reports his success with hypnotic suggestion in the treatment of severe cases, after methods of exercise, breathing, elocution, etc., had been tried to no purpose. "Though it would be difficult to trace the exact details through which the cure is effected, it is probable that in these cases it was brought about more particularly by suggestions made with a view of giving to the patient confidence in his ability to talk without stammering, though by hypnotism an influence may be exerted upon any organ or part of the body."

Pyocatin in the Treatment of Diphtheria.

In a number of collected articles by Dr. C. Höring, of Stuttgart, originally published in Betz's *Memorabilien* (*Deutsche Medizinal-Zeitung*, August 10, 1896), the author speaks enthusiastically of the local employment of blue pyocatin in cases of pharyngeal diphtheria. It should be applied several times a day. He would use the antitoxine serum in severe cases, but not to the exclusion of this local treatment.—*N. Y. Med. Journal*.

Complications and Sequelæ of Diphtheria.

The complications are those of extension to or ulceration of the respiratory tract and involvement of other regions from toxin poisoning (*The Journal of the Am. Med. Assn.*, Aug. 1, 1896; *Albany Med. Annals*). Locally there is hemorrhage, due to ulceration, from the nose, throat and bronchi; occasionally petechial hemorrhages under the skin and other skin rashes, especially erythema, appear. By extension of the process or by inhalation of particles of membrane, acute bronchitis, more especially capillary bronchitis, or bronchopneumonia with atelectasis or gangrene, may develop. Kidney symptoms are common, albuminuria is present in severe attacks;

occasionally suppression of urine is present, and, rarely, dropsy develops later. Heart failure or fatal syncope may occur at any time during the attack or after convalescence, in from 10 to 15 per cent. of cases. One of the most common is that of the velum palati. Sometimes the eye is involved and strabismus, ptosis or loss of accommodation may result. Facial paralysis sometimes occurs. One of the limbs may be involved. Occasionally multiple neuritis develops. W. S.

Delayed Paralysis after the Use of the Antidiphtheritic Serum.

Filiatre, in the *Gazette Hebd. de Med. et de Chir.*, has reported the case of a child three years old, presenting symptoms of laryngeal obstruction, which proved on bacteriologic examination to be of diphtheritic origin (*The Journal of the Am. Med. Assn.*, August 22, 1896). An injection of 15 c.c. of antitoxic serum was at once made into the right flank, and forty-eight hours later a second injection of 10 c.c. into the left flank. In the course of twelve hours the false membrane had completely disappeared, the child breathed easier, the pulse was normal, the fever had disappeared, and only the submaxillary adenopathy remained. The child continued well for more than a month, when it was observed to speak through the nose. A day later speech was almost unintelligible, and saliva dribbled from the mouth. In the course of several days more the head could not be held up, the chin falling upon the chest. Deglutition also became difficult. The knee-jerks, as well as the pupillary reflexes, were preserved. Sensibility was intact. The muscles especially enfeebled were the extensors of the neck, the rotators of the head, excepting in the sterno-mastoid, the supraspinous and the elevators and abductors of the scapulae. The facial muscles also were largely affected, as well as the recti abdominis. Under electric treatment improvement rapidly set in, and soon proceeded to final recovery. W. S.

Varicella of the Larynx.

Two cases of this rare affection are recorded by M. Marfan and T. Halle (*Revue mens. des malad. de l'enfance, Med. News*), one a boy of three years, at first thought to be diphtheria, in which case recovery took place; the other a child of nine months, which ended fatally. Stenosis of the larynx in varicella may at times be confounded with diphtheria. A bacteriological examination will serve to distinguish between the two.

On Bony Growths Invading the Tonsils.

Dr. Alex. W. Stirling reports three interesting cases of bony growth invading the tonsils (*Atlanta Med. and Surg. Jour.*). In the first

case, the young lady had been troubled for years by an enlarged and occasionally painful right tonsil, which had been treated by a number of physicians. On examination with the finger a hard, immovable substance could be felt, which appeared to come from behind the tonsil forward and underneath it to the level of its anterior surface, but forming practically a part of it. Its point is rounding, apparently about an eighth of an inch, but becoming broader and somewhat flattened laterally as it goes outward, backward and slightly upwards. The finger pressed in front of it enters an angle formed by it and the inferior maxilla, and when pressed behind it enters another angle formed by its approximation to the right side of the vertebral column. The left tonsil appeared normal.

The second case was a patient sixty-four years of age, in which a slight protuberance could be felt just about, and in front of, but involving her right tonsil. This case presents many of the characteristics described in the last case. She had never suffered the slightest inconvenience with her tonsils.

The third case was a brother of the second, who had never suffered from any throat affection, but had on both sides the peculiarity above described. The hard substance is entirely in the posterior part of the tonsil; is much longer and reaches a full finger breadth below the level of the lower border of the tonsil.

The author excludes tonsillar calculi and concludes that they are congenital peculiarities. He believes them to be elongated styloid processes somewhat diverted from their normal direction. He does not consider surgical interference justified in these cases. W. S.

Skiagraphy of Foreign Bodies in the Larynx.

Mr. Sydney Rowland, in a special report to the *British Medical Journal* (March, 1866), states that as he had the opportunity of attempting the skiagraphy of foreign bodies in the larynx, a French nail and a fish bone were attached by plaster to the side of the neck of the subject in the exact projected position of the ventricle. Exposure to the X rays was made for six minutes, and both the nail and fish bone showed clearly in the plate, thus demonstrating conclusively the possibility of recovering foreign bodies impacted in this region. The rest of the structure of the neck showed very faintly or not at all, with the exception of the vertebral column and the hyoid bone. Being mostly cartilaginous, they are very transparent to the X rays. For the practical working of the method, it will be necessary, therefore, to draw up a projected chart of the region so as to localize with greater exactitude the actual position of any body.

W. S.

Foreign Bodies in Throat.

The *Medical Times* describes a simple and unique and apparently rational method of removing foreign bodies where instrumental means may fail. The difficulty of removing fish-bones and similar obstructions impacted at the lower end of the œsophagus is well known, and various mechanical measures and appliances have been invented to deal with the difficulty. One of the most simple, however, and, as reported, one of the most effectual, is to administer to the patient a pint of milk, and forty minutes afterwards an emetic of sulphate of zinc. The fluid easily passes the obstruction, and is, of course, rapidly coagulated in the stomach into a more or less solid mass, which, on being ejected, forces the obstruction before it and so effects its removal.

Case of Obstruction of the Larynx Due to a Web.

Dr. Barclay describes the case of a man, aged 39 years, who had not had syphilis nor other constitutional dyscrasia, who had suffered for eighteen months from hoarseness and loss of voice with gradually increasing difficulty in breathing, which induced his own doctor to perform Laryngotomy (*The Journal of Laryngology*, August, 1896).

A laryngological examination showed that there was intense inflammation of the whole larynx; the vocal cords, which were in apposition, were especially affected, being intensely red, swollen, and motionless. In spite of all that was done he continued in this condition for three months. Tracheotomy was then performed and the laryngotomy tube removed. The effect of this was soon beneficial; first one vocal cord and then the other leaving the middle line, and then the anterior two-thirds of the vocal cords was found to be united by a web.

This web had been cut by Whistler's cutting dilator and dilated by Schroetter's and other bougies, and now only a small amount of web tissue uniting the under surface of the vocal cords in front persists. The tracheotomy tube has been removed, and the man is able to do his work as a farm laborer. The points of interest in this case are:

1. There is no history of syphilis, and it is believed to be an instance of a web forming after a common cold.
2. The laryngotomy tube kept up the inflammation in the larynx, and tracheotomy is, therefore, to be preferred to laryngotomy.

W. S.

A Case of Tubercular Laryngitis on which Thyrotomy has been Performed.

Dr. Bond reports the case of a patient who had suffered from sore throat for four months (*The Journal of Laryngology*, August, 1896).

He had had night sweats, had been losing flesh, and had attacks of severe suffocating coughs. He had pains shooting up to the left ear. He had lost three children from phthisis; was much emaciated, and his face pinched and sallow. No history of syphilis could be obtained. He seemed to have had slight consolidation at right apex, bronchial breathing, etc., but no rales could be heard.

The left side of the larynx was fixed. There was great swelling of the left ventricular band, which was red and coarsely granular, and at the back was superficially ulcerated. The front of the left vocal cord could be seen with difficulty. There were no enlarged glands; the voice was very husky.

A thyrotomy having been performed, the whole left ventricular band was found affected and was removed, and also the inner edge of the left vocal cord. On the posterior commissure were several papillary excrescences and the mucous membrane here was also removed. The left thyroid plate was scraped, and also the anterior commissure.

The patient left the hospital a month after the operation with the narrow sinus unhealed and with some cough. He had improved considerably, his temperature being normal and his weight increased. The larynx is somewhat deformed and congested, but there is no definite infiltration to be seen and no ulceration. His voice is feeble, owing in part to the escape of air through the sinus. The specimen removed was found to be tubercular, and tubercle bacilli have been found in the sputum.

W. S.

Epithelioma of Soft Palate.

Dr. Thos. Hubbard (*N. Y. Med. Jour.*) reports a case of epithelioma of the soft palate in which he successfully used injection of liquor potassæ. An asbestos-packed syringe with curved platinum needle was used. By the use of cotton swabs and a very dilute acetic-acid solution the mucous membrane around the growth was protected. Two injections were made. Five deep punctures were made and a portion of a drop of the solution deposited. Microscopic examination of a portion removed prior to operation confirmed the diagnosis.

Objects and Limitations of the Operations for Cancer.

Dr. Watson Cheyne, in a lecture delivered before the Medical Society of London, advises that as cancer of the tongue very soon spreads into the muscular substance the whole muscle should be removed, and that the nearest lymphatic glands should be taken away in every case (*British Medical Journal*, February, 1896). He justifies this radical operative procedure by statistics, which show the great frequency of recurrence after operation, varying from 61 to 89 per cent.

The limits of the operation for cure in case of disease of the tongue are, in the author's opinion, the following:

Very extensive infiltration of the tongue muscles, especially downwards towards the hyoid bone; extensive affection of the jaw in addition to the tongue; extension to the upper part of the larynx; and involvement of the carotid artery and vagus nerve in the large granular mass.

W. S.

Surgical Interference in Malignant Disease of the Larynx.

Dr. D. Bryson Delavan (*N. Y. Med. Jour.*), in an able article on Recent Advance in the Surgical Treatment of Malignant Disease of the Larynx, says:

"I am strongly of the opinion that, for a time at least, both the welfare of the patients operated upon and the interests of science demand that the indiscriminate performance of capital operations upon the larynx should cease. In most great centers there are individual surgeons or groups of operators who are especially well fitted, as to both personal qualifications and hospital facilities, for the successful performance of this work, as has been proved in many cases by the records which they have already made. Let such men surround themselves with the proper assistants, let them systematize their efforts, and use all diligence in the perfection of appliances and methods and in the study of the cases under them, and keep careful and accurate record of everything pertaining to the history of their work. Then resign to them temporarily the care of as many cases of laryngeal cancer as possible. When a sufficient amount of material has thus been collected, we shall learn whether the radical extirpation of laryngeal epithelioma is unjustifiable, or whether, as we have the best reasons for hoping, it is likely to establish for us a reliable means of cure."

Epithelioma of the Soft Palate Removed by Injections of Liquor Potassæ.

Complete eradication of the tumor followed this line of treatment, in a male patient, fifty years old (*New York Med. Jour.*, Thom. Hubbard, M.D., Toledo, Ohio). The disease had existed for some time, and was partly in the soft palate and partly in the pillar of the fauces on the right side. It was very painful and restricted all faecal movements. An exuberant growth of papillomatous tissue occupied the buccal surface of the cheek. The patient lived on semi-fluid diet. He became addicted to the cocaine habit, which affection was finally cured. A number of injections of liquor potassæ were given unto and around the growth, by means of an asbestos-packed syringe with a curved platinum needle. The pain was not severe. The mucous membrane in the immediate vicinity of the injections was protected

by swabbings of very dilute acetic acid. The papillomatous masses on the cheek were touched with the stick potash. The man gained rapidly in weight, and a dense, firm cicatricial mass was all that remained of the tumor. Three months later, the patient expired from pleural effusion and mitral insufficiency. M. D. L.

Adenitis of the Neck and Carious Teeth.

In an editorial appearing in the *New York Medical Journal* a German surgeon, Dr. Starck, is quoted as stating that out of a hundred children which he had examined, ranging from three to twelve years of age, suffering from this disease, in fully forty-one per cent. the exciting cause was found to be dental caries. Out of this number infections and hereditary diseases were excluded. He remarks that carious teeth are to be recognized as among the most frequent avenues of infection in children, and further emphasizes the practical point, that surgeons should extract any carious teeth which may exist in patients upon whom they operate for tuberculous glands of the neck. M. D. L.

Primary and Secondary Pharyngeal Tuberculosis.

Secondary invasion of the pharyngeal tissues is not a rare complication of a tubercular affection, but a primary manifestation is certainly not frequently observed (W. F. Chappell, M.D., in *New York Medical Journal*). The author reports such a case, which followed the removal of some adenoid tissue from the pharyngeal vault. The patient was a female, 19 years old, who suffered from post-nasal discharges and nasal obstruction. At several sittings the growths were removed with the forceps, under antiseptic precautions. A week after the last operation the patient complained of chills and pain behind the palate. Her appearance showed that she was ill. She had an ashy-gray complexion. On post-nasal examination, the mucous membrane was found inflamed and puffy in appearance, resembling adenoid growths. Some of this tissue was removed, and was found quite firm and hard. Three weeks later the cervical glands became swollen, and were quite painful and tender on pressure, especially on the right side. The lateral folds of the pharynx were enlarged, and appeared as thick nodular ridges, about the size of a lead pencil. This nodular condition also existed in the naso-pharynx. Nothing was found in the lungs, but the patient had a temperature of 101° F. Up to the time of the operation the young lady had enjoyed good health. Previous to her throat treatment she had nursed her sister, who died from an acute form of pulmonary tuberculosis. After the sister's death the young woman occupied the same room in which her sister had been, and used the same bed clothing and other things without same having been disinfected.

Under the microscope the mucus from the pharynx and naso-pharynx showed tubercle bacilli. Examination of several pieces which were removed from the right lateral pharyngeal fold demonstrated characteristic tubercle, with many giant cells. Tubercle bacilli were also found. The diagnosis made was miliary tubercle of lymphoid tissue. Local treatment was carried out, and the disease improved. Daily examinations of the lungs were made, but no lesion was discovered until four months after the pharyngeal disease, when the right apex was found affected, and shortly afterwards the left apex. The soft palate and larynx became involved, and the patient soon succumbed.

The question arises whether infection would not have occurred if the operative treatment had been omitted. In primary cases of this disease in this region the local evidences precede the swelling of the cervical glands by a few days. In secondary cases, the glands are usually affected some time before the pharyngeal involvement. The right side of the pharynx seems to be more readily infected, and this is probably due to the difference in the arrangement of the lymphatics.

M. D. L.

A Case of Perichondritis of the Larynx.

This complication occurred in a young man suffering from a specific urethritis (H. S. Birkett, M.D., Montreal, in *New York Medical Journal*). Pain on swallowing and hoarseness were the local symptoms present. Several joints were affected, and on examination of the larynx the mucous membrane was found swollen and oedematous over the left crico-arytenoid joint. The cords were normal in color, but the left one moved sluggishly. Pressure over the affected joint outside was very painful. Constant application of a Leiter's coil afforded great relief. In a week's time the disease abated, together with the disappearance of the symptoms of the other joints involved.

M. D. L.

OTOLOGICAL.

The Degenerate Ear.

In an editorial in the *American Medical Review*, September, 1896, the following interesting description of degeneration in the formation of the external ear is given:

"The ear bears a special relationship to the contents of the cranial cavity. There is even a form of external ear disease—namely, non-traumatic othaematomata—which is found most commonly among the insane. Other positive evidence of the relationship between the ear

and the brain has been shown by the examination of the ears of criminals and of the insane conducted by well-known authorities.

"The system of ear measurement instituted by Bertillon, which now bears his name, was originally begun as a part of a general and minute measurement of criminals for purposes of identification merely. It has, however, given valuable data for a classification of the characteristics of the criminal and the degenerate.

"A noteworthy and interesting paper relative to this subject appears in the *Journal of Insanity*. Dr. McCorn in this paper deals in a general way with the traits which are usually regarded as peculiar to criminal physiognomy.

"The average ear regarding size, shape, angle of insertion, etc., is taken as a normal standard. Dr. Eugene S. Talbott found (*Journal of the American Medical Association*, January 11, 1896) the average length of the ear to be 2.50 inches; average width, 1.22 inches.

"The angle of insertion, or the auriculo-temporal angle, varies very greatly. That a large angle is indicative of degeneration has been shown many times. Frigereo found that a large angle was very common in homicides; less frequent among thieves. An examination of 465 boy criminals in the Reformatory at Pontiac showed that in only 198 the ears were close to the head, being at an angle of from 10 to 15 degrees. In 152 cases the ears were at an angle of 45 degrees; while in 115 the ears stood at right-angles, or 90 degrees. A similar examination of 1,041 criminals at Elmira showed that in 285 cases the ears were close to the head; in 567 they presented an angle of 42 degrees; while in 187 they stood at right-angles.

"Excessive or arrested development of the helix constitutes a stigma. A deformity of the helix, which has become classical through the attention paid it by Darwin in the 'Descent of Man,' is a very interesting one. This deformity is a small projecting point on the free border of the unfolded helix. Darwin concluded that this point was the remnant of the animal ear, folded downward and compressed. Occasionally these tubercles are multiple.

"The anti-helix is rudimentary in apes. Investigation in this country, however, does not bear out the theory that arrested development of the anti-helix is unusually common in the criminal and in the insane.

"The anti-tragus is said to be very frequently absent among the degenerate classes.

"The formation of the lobule is considered particularly significant by neurologists, who consider a long lobule a marked sign of degeneracy. The absence of the lobule, as well as the absence of one of

the branches of the fork, or crus, of the anti-helix are considered to be stigmata of degeneration.

"Scientists and neurologists, however, are forced to lay little stress upon the occurrence of any one or two aural stigma. It is only the combination of several that carries weight as indicative of a corresponding degeneration of the cerebral tract."

International Statistics of the Deaf.

The Volta Bureau has recently published the first of a series of interesting and valuable statistics, containing the returns from nearly all the institutions for the deaf in the world.

Each school is represented in a tabulated report, recording location, name of institution, date of establishment, founder, principal or executive officer, method of instruction, number of teachers and pupils; also valuable statistics referring to the number of congenitally deaf pupils, and those who have some hearing power.

The following tables are self-explanatory:

NUMBER OF SCHOOLS AND METHODS OF INSTRUCTION.

Continents.	Schools.	METHODS OF INSTRUCTION.				
		Manual	Orn.	Manual Alphabet.	Combined.	Not stated.
Africa	5	1	2	.....	1	1
Asia	5	.....	2	2	.....	1
Australia	4	.....	.....	1	2	1
Europe	357	7	236	2	37	75
North America	100	3	27	1	67	2
South America	3	.....	.....	.....	2	1
Total, 1895	474	11	267	6	100	81
Total, 1882	397	32	239	.....	91	37

NUMBER OF SCHOOLS, TEACHERS AND PUPILS, AND CONDITIONS OF ORGAN OF HEARING OF PUPILS.

Continents,	Schools.	Teachers.	PUPILS.		
			Congeni- tally deaf.	Have some hearing power.	Totals.
Africa	5	14	21	13	72
Asia	5	11	109	30	198
Australia	4	24	94	27	160
Europe	357	2,676	5,986	3,220	21,852
North America	100	1,117	2,518	1,095	10,127
South America	3	13	32	12	74
Total, 1895	474	3,855	8,760	4,397	32,483
Total, 1882	397	2,029	.....	.....	26,473

This interesting 32-page pamphlet should be in the hands of every progressive aurist, who takes an interest in the welfare of institutions for the training and teaching of the deaf. We compliment the able superintendent of the Volta Bureau, Mr. John Hitz, for his energies and the excellence of the report.

Boxing the Ears.

It is well to direct the attention of the profession from time to time to the evil consequences of this practice.

Dr. O. F. Baerens, in *Tri-State Medical Journal*, August, 1896, presents a series of cases where boxing of the ears, either in sport, as in foot-ball, wrestling, boxing, or as a form of chastisement, has resulted in a variety of affections of the ears.

The clinical history of almost all cases who have received blows on the ears differs generally only in the intensity of the symptoms. One symptom which perhaps creates more alarm than the others is auto-phonia, a condition in which the patient feels as though his cranial cavity contained air instead of brains.

Teachers and parents should be made to understand the frequent bad effects of this method of punishment, and the attention of physicians should be directed to this class of injuries, and their influence enlisted to help abolish this practice.

Relation of the Thyroid Gland to Certain Diseases of the Ear.

Dr. Edmund D. Spear, in an article published in the "Boston City Hospital Medical and Surgical Reports," summarizes his carefully-prepared paper as follows:

"Cases of progressive disease of the ears, occurring in patients whose nervous organization is not normal, and who usually complain of hearing roaring or ringing noises, whose ears upon examination with mirror and speculum present slight ulcerations, are found to have lost the power of hearing the lower tones of the musical scale. Among these cases a large percentage have a noticeable enlargement of the thyroid gland, and all have swelling or hypertrophy of the turbinate bodies. The displacement of the malleus and locking of the malleo-incudal joint, brought about by the closure of the Eustachian tube in the consequence of the lack of inhibitory action upon the turbinate body by the thyroid gland, is, in the early stages of these affections, the cause of the impairment of hearing. In the latter stages of the disease a fixation of the other ossicles takes place, until the stapes finally become firmly set in the niche of the foramen ovale, thus producing almost complete loss of sound conduction.

"I here purposely omit more than a reference to the neurotic ele-

ment which enters so fully into these cases, and which explains the inability of many patients to use their ears for any length of time without exhaustion."

The Telephone and Its Application to the Deaf.

In calling attention to the application of the telephone as an assistance to those markedly affected, the author, B. Thornton, London, (*The Lancet*) states that in every institution for the education of deaf mutes probably from ten to twenty per cent. of the children possess some degree of hearing. He has found that with the use of a modified mouth-piece and receiver the voice could be readily heard. To those totally deaf the only method of service is labial expression and the sign language.

[We at times observe that, in cases of partial nerve deafness, repeated and systematic word lessons on the part of the physician will accomplish some good towards re-establishing the function of a degenerate nerve and receptive centre. The telephone offers a means by which a definite quantity of sound vibrations can be applied; and this vibratory massage, together with acquainting the dormant auditory centre with familiar tones, may probably prove of great service.—ED., M. D. L.]

Chronic Otorrhea Permanently Cured with Trichloracetic Acid.

Halasz confirms Okuneff's announcement of the value of this treatment, and recommends the following *modus operandi*: As the pain is severe, five to eight drops of a 10-per-cent. solution of cocaine should be held in the ear for three minutes (*Therap. Woch.*; *The Journal of the Am. Med. Assn.*, Aug. 22, 1896). During this time a syringe of tepid water should be used to melt the crystals of the acid on the specially constructed sound. The ear is then lighted, and the sound introduced into the middle ear through a rubber ear-speculum. Every spot to be cauterized should then be touched lightly but effectively with the acid, especially the edges of the perforation and the mucous membrane of the middle ear. The ear should then be rapidly rinsed out with one or two syringes of water, and after it is dry dusted with aristol or powdered borax blown in. The operation should be rapid, and repeated once or twice a week, when the otorrhea soon disappears, the perforation in the drum closes, and the hearing is completely restored.

W. S.

Pyrozone and Dilute Hydrochloric Acid in Suppurative Inflammations of the Middle Ear.

This combination is highly recommended in suppurative manifestations of the middle ear after acute symptoms have subsided. The

author, Wm. Cheatham, A. B., M.D., Louisville (*Med. Record*), has derived excellent results with this solution in chronic cases where other means have failed. Ten drops of dilute hydrochloric acid to one ounce of pyrozone is the proportion employed. Of this, ten drops are placed in the canal, once, twice or three times daily, after the ear has been cleansed. The solution is then left in the ear about five minutes, and forced into the middle chamber by pressure upon the tragus. Drainage can be continued by the use of strips of iodoform gauze placed in the canal.

M. D. L.

Brain Abscess and the Middle Ear.

Dr. B. F. Church, in the course of an interesting article in the *American Medico-Surgical Bulletin* on "Acute Inflammation of the Middle Ear," says:

"In reviewing the literature of suppurating diseases of the brain and its membrane, the fact is apparent that a very large majority of these cases come from either an acute or a chronic suppuration of the middle ear; in fact, if trauma and tuberculosis are eliminated as causes of brain abscess, we would seldom err to lay all of them at the door of middle ear disease."

That this is so is recognized by all experienced aurists. Too much emphasis cannot be given to the necessity for the general practitioner to watch the ears of his little patients, and in case of the presence of any inflammatory trouble, especially during the course of the exanthematous diseases, to either be prepared to properly attend to this portion of the case or call in some one who can.

Case of Sigmoid Sinus Thrombosis.

At a meeting of the Glasgow Pathological and Clinical Society the author, Dr. J. K. Love (*Glasgow Med. Journal*), presented a female patient who recovered from a lateral sinus thrombosis following a suppurative otitis media of eight weeks' duration. The interesting feature of the case is that, though the sinus contained a thrombus, same was not disturbed. Symptoms of optic neuritis, dilated and sluggish pupils, epigastric pains, diarrhea and vomiting were present. A mastoid operation was performed, but the above symptoms persisted, and a portion of the bony boundary of the sinus was removed with evacuating the clot.

[Absorption fortunately took place; but where a thrombus can be demonstrated, as in this instance, we certainly give the patient a better chance by removing same, thus get rid of the irritating and septic factor.—M. D. L.]

Sarcoma of the Base of the Skull, Involving the Ear.

In the *Australasian Medical Gazette*, Dr. C. H. Hogg, of Tasmania, reports a rare and interesting case of sarcoma of the base of the skull, involving the temporal area, in a child four-and-a-half years of age. The development to a fatal termination was remarkably quick.

With regard to some of the symptoms in this case, headache was absent during the greater part of the period; vomiting was absent at first, and even later when present was not severe; neuro-paralytic ophthalmia, which was present, is of frequent occurrence in tumors of the base, more especially of the middle fossa, where they involve the Gasserian ganglion.

The post-mortem examination revealed an extensive growth of the base, involving the parts to such an extent that it was impossible to remove the brain in its entirety. The growth, which seemed to have sprung originally from the body of the sphenoid bone, had so eroded the base of the skull that on dissecting out the growth, the pharyngeal wall was exposed. The tumors had involved the basilar process of the occipital bone and the apex of the petrous portion of the left temporal bone, through the latter of which it had gained access to the tympanum. The bones affected were soft, and could be pulled into pieces by the dissecting forceps. The surface of the pons was adherent to the mass, and had to be dissected away from it.

Microscopic examination showed the growth to be a round-celled sarcoma.

Of tumors of the base, sarcomata are the most frequently met with, and as a rule start in the dura, or more rarely in the bone.

Although it is not uncommon to find tumors eroding other parts of the skull, such an occurrence is much rarer in tumors of the base. In this case, not only had the tumor eaten through the base, but it had also made its way through the petrous portion of the temporal bone into the ear, and perforating the membrana tympani appeared as a polypoid growth in the external ear.

Such a condition is of rare occurrence, and we meet with few similar cases in literature.

NEW INSTRUMENTS.

Hawkbill Nasal Scissors.

Dr. J. C. Lerter (*N. Y. Med. Jour.*) has devised a hawkbill nasal scissors, made by G. Tiemann & Co., that removes a V-shaped piece of the bone. He claims, by this method of operation, that the major part of the mucous membrane remains intact, and that after the cut surfaces are brought together a space sufficiently large for perfect respiration remains.

A New Tracheotomy Tube.

Dr. De Santi describes a tube adapted for patients who have to wear a permanent tube, and who have sufficient space to expire through the larynx, though not room enough for inspiration (*Journal of Laryngology*, Aug., 1896). The tube is fitted with a small metal hollow plug, with a small rim below, and in the plug is fitted a metal hinge valve, something like a sewer trap; on inspiration the valve opens and the patient breathes through his tube; on expiration the valve closes tightly and air passes through the larynx. The advantages of the plug and valve are:

1. That the patient can speak distinctly and without putting his fingers on the tracheotomy tube.
2. That he coughs up mucus, etc., through the larynx and out of the mouth, normally.
3. That the patient is able to wear a collar and shirt and go about comfortably.

If the removable plug becomes blocked with mucus it is taken out and boiled, and in the meanwhile a fresh plug is inserted. It is of course necessary that there should be an opening of the tracheotomy tube in the ordinary place at its greatest convexity. W. S.

A New Self-Retaining Nasal Speculum.

Dr. J. R. Straw, of Ashland, Wis. (*Journ. Am. Med. Assn.*), describes a nasal speculum claimed to be absolutely self-retaining. The speculum consists of three fenestrated or solid blades, mounted on a square base. The central blade is stationary; those on either end are movable. To apply the instrument, the central blade is inserted on the side of the septum of the nares to be examined; the distal blade is then pushed toward the septum, the septum being thus clamped between the distal and central blades, thus preventing any slipping of the instrument. The third blade is then pressed out against the alae of the side to be dilated. The movable blades are self-locking, on the Lennox-Browne principle.

SOCIETY PROCEEDINGS.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Twenty-second annual meeting, held at St. Paul, September 15, 16, 17 and 18, 1896.

SUMMARY OF PAPERS AND DISCUSSION.

A New Operation for Cleft Palate.

Dr. Truman W. Brophy, Chicago, took the ground that the operation should be performed much earlier than has been the custom of surgeons heretofore. It has usually not been thought advisable to operate for the closure of cleft palate until the child has reached the age of two to five years. He maintains that when the operation was thus postponed the changes in the voice had become permanent, and a repair of the cleft at that time would not react favorably in the voice production. His operation consisted in freshening the edges of the cleft, then by deep suture of silver wire fixed through a lead plate, conforming to the palate, the edges of the cleft are drawn together and so maintained until healing takes place. The technique of the operation was minutely explained. It was original with the author, and in his experience has proven most effectual.

Dr. W. F. Daley, of Pittsburg, said that this method does away with all the objections to the old operations. "We all know that in some cases we were compelled to operate four or five times, and then consider ourselves fortunate if we succeeded in getting a perfect result. Even in these cases the result was never perfect, inasmuch as we could not at that late date teach our patients a perfect speech."

The Treatment of Experimental Tuberculosis in Animals by the Use of Blood Serum.

Dr. Paul Paquin, of St. Louis:

The use of antitoxin goes back to the active principle underlying immunization, an agent which is itself curative to a certain degree.

Tuberculin is, to a degree, capable of modifying certain forms of tuberculosis. The inconvenience resulting is chiefly in the more or less severe reaction following. It is now claimed that tuberculin may be made with this poisonous principle eliminated.

Experiments in guinea pigs unfortunately do not give the same results that they do in the human subject. Furthermore the experience of investigations with the serum therapy treatment of tuberculosis

varies greatly in different cases. They all, however, demand of any treatment absolute cure of tuberculosis when used in the human. We have been busy with all possible and varied forms of experimentation in the smaller animals; but we are not always able to properly interpret the results of any given form of treatment and then make an exact application of those principles to man as a reliable guide.

In guinea pigs inoculated with tuberculosis and then treated with serum 10 per cent. were saved. Later results show very much higher percentage than this—from 25 per cent. to 55 is favorable. In the human, 226 cases showed about 60 per cent. favorable, with 40 recoveries and 120 improved. Antitubercle serum is positively curative in many cases; it has passed the experimental stage, but yet we know it is not perfect. From my own, and the experience of others, it will be observed that only a relative number of tuberculous patients can with our present knowledge of tuberculosis and antitubercle serum be treated successfully. If it does not succeed it is because of existing conditions, such as intolerance to serum injections of any kind, which is very rare; general destruction of physiologic equilibrium beyond repair; incurable lesions or mixed infection.

Dr. Longstreet Taylor, of St. Paul: It is not necessary that the serum should produce an antitoxin in the body. It will in many cases give most gratifying results, but in others, for some reason, it is just as disappointing. My experience with the Paquin serum has not been entirely satisfactory, but I intend to give it further tests.

Dr. W. F. Barclay, of Pittsburg: I am satisfied that some such men as Paquin will demonstrate the ultimate success and positive value of antitubercle serum, and hope criticism will not discourage him and others.

Dr. H. W. Loeb, of St. Louis: At the last meeting I presented some reports relative to the treatment of laryngeal tuberculosis with serum. I promised at that time to report the results. While they have not been as good as we had hoped, yet they are such as to encourage still further attempts. Knowing that these cases at best are almost always fatal, we as well as the patient are glad to try anything that gives the least hope of a cure. Of the cases reported at least two are yet living and well. Of two others I cannot say, but at latest reports there was no return. I believe the serum treatment will eventually be the method, but we must go further before we can say it is a specific.

Dr. Charles Green, of St. Paul: The fallacy of medical statistics is best shown by tuberculosis. I do not have much confidence in any such.

Dr. Joseph Muir, of New York: All other "cures" are claimed to have some specific or selective action, but Dr. Paquin has not said what is the selective action in the serum therapy treatment. I am convinced a change in the home surroundings of many cases will do more toward a cure than a change of climate.

Dr. Paquin, in closing, said: I agree with all who have said that nature must come to our assistance in these cases. There are so many complications usually that we can scarcely hope to cope with all of them successfully. Digestion and the nervous system must be always considered.

A Demonstration of the Therapeutic Action of the Antitoxin.

Dr. E. M. Houghton, of Detroit, reviewed the theories of serum therapy demonstrating the difference between toxins and antitoxins. It has not as yet been shown just how the antitoxin counteracts or destroys the toxin. I have brought six guinea pigs for demonstration. I will inject three of these with the toxin cultures; the other three with the antitoxin and toxin.

The discussion of the paper was postponed until the results of the injection on the animals should be determined.

Reinfection in Consumption.

Dr. Joseph Muir, of New York, said: Statistics show that a first attack is not usually fatal, and death is often found to be due to other causes. Primary infection is not usually due to inherited tendencies, but external conditions play a most important part. Consumption is best treated among the rich; frequently indeed a permanent cure is effected in this class of cases; so, for evident reasons those who are poor should be given especial attention. Patients who have been cured must not be allowed to return to their former environment. Redevelopment is inconsistent with clinical experience.

Change of air and outdoor exercise and labor hardens and freshens the tissues, and the respiratory impurities of former environment are no longer present. Reinfection may be prevented by:

First. Thorough disinfection of the patient and surroundings.

Second. Destruction of the sputum.

This protects the patient against himself.

Dr. H. J. O'Brien, of St. Paul: I am satisfied there are many cases of reinfection. I have sent them away, and in six months they would come back to die; by staying away they will sometimes escape contagion and reinfection.

Dr. J. A. Larrabee, of Louisville: I have long believed if a consumptive could have these conveniences and this care in the beginning,

along with a stuffed feeding, that in many cases we could check or abort entirely the disease. The most terrible mistake is made in sending subjects away for treatment. Home is best, no matter where that home is. Improve it all that is possible, but leave them among friends. I think there is much in this idea of reinfection.

Dr. R. H. Babcock, of Chicago: The author of course does not claim all cases are of infection. I wish to emphasize in the strongest possible terms the idea that if sent away and they improve they must stay away permanently.

Tonsillotomy by Cautery Dissection.

Dr. J. Homer Coulter, of Chicago: No subject in surgery or medicine has been much more prolific in interest and discussion than that of the tonsil. In the past ten years over 600 papers have been written on that subject alone. The size of the normal tonsil is still a subject of discussion with throat specialists. Some claim there is normally no tonsil to be seen; however, the most usual opinion is that there exists normally a collection of follicles between the pillars of the fauces, protruding slightly above them. The tonsil is an almond-shaped gland, larger at one end than the other and somewhat flattened.

The methods usually employed for its ablation are the guillotine, *ignipuncture*, the cold or cautery snare, or the knife. Each of these methods have practical objections to their use. Most important of these objections, and one which applies to all of them, is the fact that by no one of them can the gland be taken out. Unless this is done the part remaining will oftentimes produce as much trouble as did the former condition. The operation I propose obviates this objection entirely if properly performed.

With a well-heated small electrode the pillars are dissected away from the tonsil to one-half its extent. The gland is then, with suitable forceps, drawn well out and thoroughly and entirely dissected out to about one-half its extent. This portion is then cut off and the surface treated with a strong solution of silver nitrate. In a week or ten days the other portion of the tonsil is removed in the same manner. This operation will give cosmetic as well as practical results unobtainable by any other process yet suggested.

Dr. H. W. Loeb, of St. Louis: I believe most decidedly in what the doctor has said about the lack of skill of many who attempt to remove the tonsils by the ordinary method. Very often they will take a piece off, and by showing that to the patient or his friends they imagine he has performed tonsillotomy. If the operator could see that

patient five or six years later, suffering from the same affections to which the remainder of the tonsil becomes subject, I think he would not be so well pleased. Removing a part can only improve the symptoms then present, and it does not signify that the tonsil will remain quiescent. It is unfortunate so valuable a method is not applicable to young children; in adults I do not think it can be improved upon. I have been practicing this method with some modification for some years. Instead of performing so much dissection it has been my plan to remove so much of the tissue as I could get in an electric snare. This is repeated as often as may be necessary to remove all the glandular substance. I think the method causes less soreness and less pain than that of Dr. Coulter, and in many cases, particularly children, the results will be just as satisfactory. Furthermore my method is applicable in case of young children.

This method of dissection is one that must commend itself in a great number of cases as being the very best possible. I most heartily agree with the author that removal of the whole tonsil is an absolute requisite if you wish to cure your patient. As to the voice changes suggested by some, I believe ablation of the tonsil does have a decided effect on the voice register, but I also believe it is always in the way of improvement. I also desire to state my disbelief in the uric acid diathesis having anything to do with tonsillitis, further than as a concomitant condition. I shall certainly provide myself with the special instruments used by Dr. Coulter, and further investigate the operation. When in Chicago I had the opportunity of seeing some of these cases, and I must say for cosmetic results I have never seen the equal.

Submucous Linear Cauterization ; a New Method for Reduction of Hypertrophies of the Conchae.

Dr. Norval H. Pierce, of Chicago, called attention to the various methods ordinarily used for the reduction of such hypertrophies, and showed the disadvantages of such. The differentiation between hypertrophy and turgescence was pointed out. The operation proposed by the author was as follows: A small incision is made in the hypertrophied membrane; then with a blunt flat probe the mucus membrane is carefully separated from the erectile tissue underneath. Then a sound, the end of which is cup-shaped, and upon which has been fused a few crystals of chromic acid, is inserted in the incision and the track already made by the probe is thus cauterized. The advantages of this method are that there is no hemorrhage. It is less painful than by any other method. The functional activity of the mucous membrane

is not in the least impaired. Patients will submit to this operation more willingly than to the burning of the cautery. The method is the most simple of any yet suggested. The reaction is usually insignificant. There is no slough. The danger of atresia is obviated.

Dr. Coulter complimented the author on the originality of his method and its various points of excellence, at least theoretically present. The main object to be attained is not only the reduction of hypertrophy, but as well the retention of functional activity. Many operators in using the cautery destroy too much of the mucus membrane and do not go deep enough to remove or destroy any practical amount of the tissue underneath, which in reality is the pathological condition present. He suggested the possibility of the chromic acid being left within the operative field, in which case an undesirable slough would necessarily follow.

The practice of many rhinologists in using a broad flat electrode, and destroying a large amount of the mucous membrane, and in not going down to the bone, is to be deplored as irrational, unscientific and impracticable, inasmuch as by such measures they do not cure the hypertrophy, but do very materially reduce the functional capacity of the nasal mucous membrane.

Dr. W. L. Ballenger, of Chicago: You, who have used this cautery must have learned to use it with more caution than you once did. The rationale of Dr. Pierce's operations is certainly an ideal one. If the hypertrophy can be removed without the destruction of any mucous membrane, little more is to be desired.

Dr. H. W. Loeb, of St. Louis: It seems to me this operation is a thoroughly scientific one, if we can thus preserve the mucous membrane and its function. It occurs to me that antisepsis and asepsis would both be a necessity with this method. I would like to ask why we could not use a platinum wire properly made and introduced in the same manner. I have seen blindness result from cauterization of the inferior turbinates; is there danger in the use of the chromic acid by this method?

Dr. Stuckey: We must determine whether it is an hypertrophy or simply a turgescence. If the latter, it may be simply an acute condition caused by some idiosyncrasy. If a true hypertrophy, this method would seem to be an excellent one, requiring, however, a considerable amount of technical skill. I am becoming more and more skeptical in the use of cocaine in the nose. There is the greatest danger of producing cocaine habitues by its use. I am able to get the same results without danger and less systematic disturbance by the use of a harmless solution of acetanilid.

Diseases of the Nose and Throat in Children.

Dr. W. F. Barclay, of Pittsburg, dwelt particularly on the possible results of acute and chronic purulent and muco-purulent rhinitis in children, pointing out not only the necessity for more attention by the family physician, but as well demonstrating that almost, if not all of the pathological conditions in the nose occurring in later life, have their origin in this condition in childhood.

The paper throughout was an unusually practical and interesting one—practical because we see it daily demonstrated in our professional life. Children should be taught to breathe through the nose rather than the mouth. Parents should be taught that surgery can relieve, very easily, those who are unable to breathe through the nose.

OFFICERS FOR 1897.

President—Dr. Thomas Hunt Stuckey, Louisville.

First Vice-President—Dr. Chas. A. Wheaton, St. Paul.

Second Vice-President—Dr. Paul Paquin, St. Louis.

Secretary—Dr. H. W. Loeb, St. Louis.

Treasurer—Dr. W. N. Wishard, Indianapolis.

Member of Judicial Council—Dr. H. T. Patrick, Chicago.

The next place of meeting was appointed at Louisville, the third Tuesday of September, 1897.

Dr. H. Horace Grant was elected chairman of the committee of arrangements.

With a vote of thanks to the retiring officers, committee of arrangements and good people of St. Paul, the association adjourned.

BOOKS AND PAMPHLETS RECEIVED.

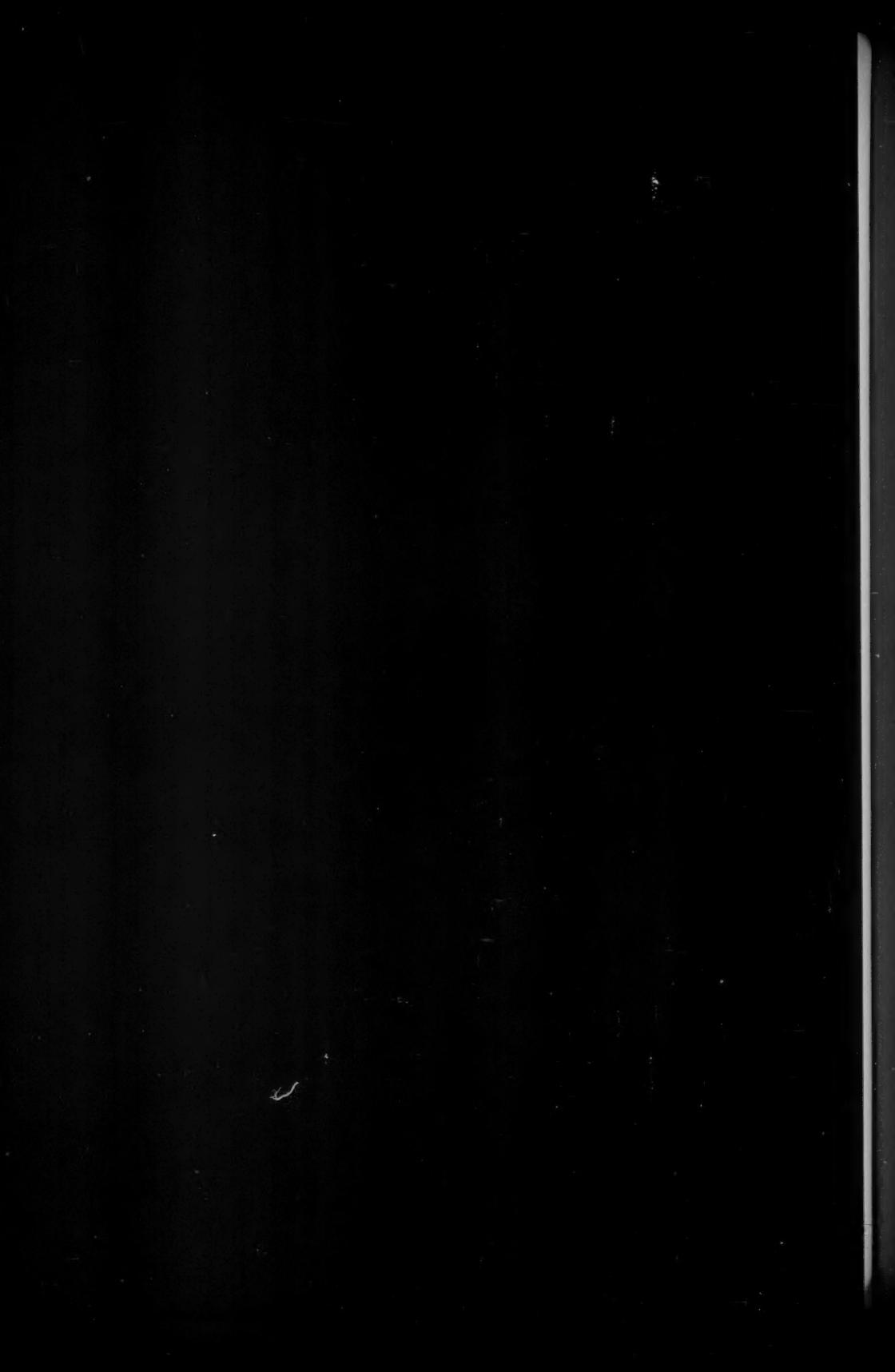
Intra-Tympanic Disease. By Jos. E. Willetts, M.D., Pittsburg, Pa. Reprint, *Pittsburg Med. Rev.*

The Relation of the Thyroid Gland to Certain Diseases of the Ear, with a Theory of Its Functions. By Edmund D. Spear, M.D. Reprint, "Boston City Hospital Medical and Surgical Reports."

Circular No. 3, International Reports of Schools for the Deaf, made to the Volta Bureau. December, 1895.

Cerebral Disease Following Middle Ear Suppuration. By M. D. Lederman, M.D. Reprinted from the *Jour. of the Am. Med. Association.*





ANNOUNCEMENT.

After due deliberation, and correspondence with prominent colleagues in every representative medical center, we have started the publication of **THE LARYNGOSCOPE**—a 64-page monthly journal, devoted to the Diseases of the Nose, Throat and Ear, for General Practitioners and Specialists.

We will endeavor to occupy a middle ground between the general and strictly special journals, and interest that large body of progressive physicians to be found in every town and city who, from time to time, are called upon to treat diseases of the nose, throat and ear.

The presentation of **THE LARYNGOSCOPE** is an innovation in medical literature, as there is no monthly journal representing these specialties published in America.

Contributions to the Original Department of **THE LARYNGOSCOPE** will be of such a nature as will appeal to both the general practitioner and specialist.

Our Editorial Staff represents each section of the country, and we will be thus enabled to give our readers the special sentiments and gleanings, society proceedings, and clinical progress from every representative medical center.

A staff of Foreign Editors will, by their correspondence, keep our subscribers posted as to the special advances made in their respective countries in the field which we intend to cover.

In this progressive era of "specialization" in medicine, and the ever-increasing demand thus made on the profession for more accurate and delicate work, the necessity of such a journal as we desire to make **THE LARYNGOSCOPE** will soon be felt; and we shall endeavor by every means in our power to make it an influential factor in medical journalism, and a worthy champion of the field of work which it represents.

In order to place the journal within the reach of all, the subscription price has been placed at \$2.00 per year.

We respectfully request the active support of the medical profession.

THE EDITORS.

Ferratin

Lactophenin

THE MERITS
OF OUR
Cocaine

as a first-class, thoroughly reliable preparation, have long since been fully recognized by the majority of physicians, surgeons and chemists, and more especially has it been distinguished by the approbation of :

Dr. CARL KOLLER, of New York.

(Formerly of Vienna, the first to apply Cocaine in Medicine.)

Dr. BENJ. H. PAUL, of London.

Professor Dr. SCHROETTER, of Vienna.

Professor STOERK, of Vienna.

Professor STELLWAG, of Vienna.

Professor Dr. JURASZ, of Heidelberg.

Professor Dr. E. FISCHER, of Strassburg.

Professor Dr. RIEDINGER, of Wurzburg.

Professor Dr. G. DRAGENDORF, of Dorpat.

Dr. K. EMELE, of Graz.

Dr. LEOPOLD LANDAU, of Berlin.

Dr. HERRNHEISER, of Prague.

Professor CASIMIRO MANESSEI. (Pres. of the Italian Section
of the International Medical Congress of Paris.)

Dr. G. B. DANTONE, of Rome.

Dr. AUG. RITTER VON REUSS. (Professor of Ophthalmology,
Royal and Imperial University, Vienna.)

Professor Dr. SCHIEBE, of Prague.

Professor Dr. U. MOSSO, of Turin.

Professor M. A. TICHOMIROFF, of Moscow; etc.

Cocaine Hydrochlorate, B. & S., occurs in beautiful, well-defined crystals, and entirely free from Amorphous matter, from other Alkaloids, and from Benzoylecgonin. It stands Maclagan's and every other Test.

Supplied in 5, 10 and 15 grain vials, and in $\frac{1}{8}$, $\frac{1}{4}$, $\frac{1}{2}$ and 1 oz. bottles.
Dispensed by all Druggists.

C. F. Boehringer & Soehne,

7 Cedar St., New York.

Always Specify

“BOEHRINGER”

(B. & S. BRAND).

Papain

Cocaine

